STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 43988 Based on observation, interview, and record review, the facility failed to provide care in a manner that maintained or enhance a resident's dignity and respect in full recognition of their individuality for one (1) of 1 sampled resident (Resident 13) reviewed for dignity when Certified Nursing Assistant 5 (CNA 5) failed to provide privacy while providing care to Resident 13. This deficient practice had the potential to affect the resident's self-esteem and self-worth. Findings: During a review of Resident 13's Admission Record, the Admission Record indicated the facility originally admitted the resident on 11/11/2024 and readmitted the resident on 11/112024 with diagnoses including dementia (a progressive state of decline in mental abilities), abnormalities of gait and mobility, and generalized muscle weakness. During a review of Resident 13's History and Physical (H&P), dated 11/11/2024, the H&P indicated Resident 13 can make his needs known but cannot make decisions. During a review of Resident 13's Minimum Data Set (MDS, a resident assessment tool), dated 11/13/2024, the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated Resident 13 required total assistance with bathing, and lower body dressing; substantial/maximal assistance with toileting, upper body dressing, personal hygiene, sit to stand, and chair/be to chair transfers; partial/moderate assistance with all other activities of daily living (ADLs, routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident was always incontinent of bowel and bladder. During a concurrent observation and interview on 2/15/2025 at 8:43 a.m. inside Resident 13's room, observed CNA 5 providing care to Resident 13 who was turned on his side exposing the buttock while the privacy curtain was halfway closed. CNA 5 stated the Charge Nurse (CN) just came to talk to her and she forgot to fully close the curtain and continued providing care to the resident. CNA 5 stated she should have closed the curtain after talking to the CN. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 2/15/2025 at 10 a.m. with CNA 5, CNA 5 stated every time they are providing care to the residents, privacy should be maintained by fully closing the curtain. CNA 5 stated it was a dignity and privacy issue and residents could feel embarrassed if other people observe the provision of care to them (residents). During an interview on 2/15/2025 at 4:30 p.m. with the Director of Staff Development (DSD), the DSD stated during ADL care, the staff especially the CNAs should fully close the privacy curtain. The DSD stated CNA 5 should have fully closed the privacy curtain while providing care to Resident 13 to preserve the resident's dignity, self-esteem, and self-worth. During an interview on 2/17/2025 at 4:32 p.m. with the Director of Nursing (DON), the DON stated when providing care to the residents, the staff should provide privacy by fully closing the privacy curtain after introducing themselves and explaining to the resident what they will de doing. The DON stated CNA 5 should have fully closed the privacy curtain while providing care to Resident 13 so the resident would feel respected and not embarrassed. The DON stated it was a dignity issue. During a review of the facility's policy and procedure (P&P) titled, Quality of Care-Dignity, last reviewed on 1/2025, the P&P indicated: - Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. - Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42311 Based on interview and record review, the facility failed to obtain written verification of informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for two of five sampled residents (Resident 32 and 76), or resident representative by failing to: 1. Ensure Resident 32's choice to consent (give permission) or not to consent for the use of bupropion (medication used to treat depression [a common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest in activities once enjoyed]) was documented in the informed consent. 2. Ensure Resident 76's choice to consent or not to consent for the use of venlafaxine (medication used to treat depression) was documented in the informed consent. These deficient practices violated the residents' and responsible representatives' rights to make an informed decision. Findings: a. During a record review of Resident 32's Admission Record, the Admission Record indicated the facility admitted Resident 32 on 5/17/2021, with diagnoses that included metabolic encephalopathy (a condition where the brain does not function properly due to an underlying metabolic imbalance), generalized muscle weakness and depression. During a record review of Resident 32's History and Physical (H&P - a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings,) dated 10/16/2024, the H&P indicated Resident 32 did not have the capacity to understand and make decisions. During a record review of Resident 32's Minimum Data Set (MDS - a resident assessment tool), dated 12/15/2024, the MDS indicated Resident 32's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 32 was on an antidepressant (medications used to treat symptoms of depression). During a record review of Resident 32's Physician Order, dated 10/14/2024, the Physician Order indicated bupropion hydrochloride extended release, give 150 milligrams (mg - metric unit of measurement, used for medication dosage and/or amount) by mouth one time a day for depression manifested by lack of motivation with activities of daily living. During a record review of Resident 32's Informed Consent, dated 10/14/2024, the Informed Consent did not indicate if Resident 32's Representative agreed on bupropion administration. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 32's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 10/2024 and 11/2024, the MAR indicated Resident 32 received bupropion on 10/15/2024, 10/17/2024 to 11/25/2024. During a concurrent interview and record review, on 2/16/2025, at 2:34 p.m., with the Assistant Director of Nursing (ADON), Resident 32's Physician Order, dated 1/14/2024, and Informed Consent for bupropion, dated 10/14/2024, was reviewed. The ADON stated the Informed Consent, dated 10/14/2024, did not indicate if Resident 32's Representative consented or did not consent for bupropion administration. The ADON stated nurses should fill the Informed Consent completely. The ADON stated the importance of completed Informed Consent was to indicate if the nurses can give the ordered medication and its Resident Representatives right to be informed. b. During a record review of Resident 76's Admission Record, the Admission Record indicated the facility admitted Resident 76 on 10/17/2023, with diagnoses that included unspecified (unconfirmed) noninfective (something is not able to be caught or spread from one person to another) gastroenteritis (an inflammation of the stomach and intestines that causes diarrhea, vomiting, and abdominal pain) and colitis (inflammation of the colon, or large intestine), depression and generalized weakness. During a record review of Resident 76's H&P, dated 12/17/2024, the H&P indicated Resident 76 had the capacity to understand and make decisions. During a record review of Resident 76's MDS, dated [DATE], the MDS indicated Resident 76's cognitive skills for daily decisions were moderately impaired. The MDS indicated Resident 76 was on an antidepressant. During a record review of Resident 76's Physician Order, dated 12/16/2024, the Physician Order indicated venlafaxine hydrochloride extended-release oral tablet 75 mg, give 75 mg by mouth one time a day for depression manifested by verbalization of sadness. During a record review of Resident 76's Informed Consent, dated 12/16/2024, the Informed Consent did not indicate if Resident 76 agreed to receive venlafaxine. During a record review of Resident 76's MAR, dated 12/2024, the MAR indicated Resident 76 received venlafaxine on 12/17/2024 to 12/19/2024 for depression. During a concurrent interview and record review, on 2/17/2025, at 7:37 a.m., with Registered Nurse (RN) 3, Resident 76's Informed Consent for venlafaxine, dated 12/16/2024, was reviewed. RN 3 stated Resident 76's Informed Consent did not indicate if Resident 76 consented or not to the use of venlafaxine. RN 3 stated RN 4 should have completed the Informed Consent before medication administration. During an interview, on 2/17/2025, at 8:09 a.m., with the ADON, the ADON stated RN 4 did not complete Resident 76's Informed Consent for venlafaxine. The ADON stated medication should not be started since Informed Consent did not indicate if Resident 76 agreed to the use of venlafaxine. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 2/17/2025, at 5:13 p.m., with the Director of Nursing (DON), the DON stated Informed Consent should be complete and if incomplete, it is not valid. The DON stated medication should not be administer if informed consent was not complete. During a record review of facility's policy and procedure (P&P) titled, Verification of Informed Consent for Psychotherapeutic Medications (a class of medications used to treat mental health conditions), dated 6/2024, last reviewed on 1/14/2025, the P&P indicated, Each resident has the right to be free from psychotherapeutic drugs and to provide informed consent before treatment with psychotherapeutic drugs. The facility will obtain a written informed consent for treatment using psychotherapeutic drugs and consent renewal every six months. Before prescribing psychotherapeutic drugs, the Physician must personally examine the resident and obtain informed written consent signed by the resident or the resident representative along with the signature of the health care professional declaring the required material information has been provided. Signed written consent will be recorded in the resident's medical record. Before initiating treatment with psychotherapeutic drugs, facility staff must verify that the resident's health record contains written informed consent with the required signatures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of resident needs and preferences by failing to ensure the call light (an alerting device for nurses or other nursing personnel to assist a patient when in need) was within reach for two (2) of three (3) sampled residents (Residents 1 and 77) reviewed under the Environment task. This deficient practice had the potential to result in the delay of care and services and possible injury to residents when they are unable to call for assistance. Findings: a. During a review of Resident 1's Admission Record, the Admission Record indicated the facility originally admitted the resident on 11/14/2014 and readmitted the resident on 10/10/2024 with diagnoses including dementia (a progressive state of decline in mental abilities), abnormalities of gait and mobility, and generalized muscle weakness. During a review of Resident 1's History and Physical (H&P) dated 11/4/2024, the H&P indicated Resident 1 can understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 12/2/2024, the MDS indicated Resident 1 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required substantial/maximal assistance with sit to stand and total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 1's fall risk assessment dated [DATE], 9/3/2024, and 12/6/2024, the fall risk assessments indicated the resident was a high risk for falls. During a review of Resident 1's care plan (CP) on at risk for falls related to aging, multiple medical problems, impaired mobility and weakness initiated on 12/1/2014 and last revised on 2/3/2025, the CP indicated to ensure the resident's call light is within reach and encourage to use for assistance as needed as one of the interventions to prevent falls. During a review of Resident 1's Order Summary Report, the Order Summary Report indicated a physician's order dated 11/27/2024 for call light placed within reach. During a concurrent observation and interview on 2/14/2025 at 9:35 a.m. inside Resident 1's room with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 1's call light was not clipped to the bed and was on the floor and not within Resident 1's reach. LVN 1 stated before to leaving the room, the staff should make sure all residents' call light should be within reach. LVN 1 stated Resident 1's call light should have been clipped to the sheet and within the resident's reach so Resident 1 can call for assistance when needed and her needs attended promptly. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/17/2025 at 4:55 p.m. reviewed Resident 1's Order Summary Report, care plans, and fall risk assessments with the Assistant Director of Nursing (ADON). The ADON stated Resident 1's physician's order and care plan indicated to place call light reach and the fall risk assessments indicated Resident 1 was a high risk for falls. The ADON stated the staff should ensure all residents' call light is within reach prior to leaving the room so the residents can call for assistance and the staff can attend to their needs. The ADON stated Resident 1's call light should have been clipped to the sheet and within the resident's reach so the staff can attend and meet Resident 1's needs timely. During a review of the facility's policy and procedure (P&P) titled, Answering the Call Light, last reviewed on 1/14/2025, the P&P indicated the following: - When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. - Answer the resident's call as soon as possible. b. During a review of Resident 77's Admission Record, the Admission Record indicated the facility admitted the resident on 4/1/2024 with diagnoses including dementia (a progressive state of decline in mental abilities), history of falling, and generalized muscle weakness. During a review of Resident 77's H&P dated 4/4/2024, the H&P indicated Resident 77 did not have the capacity to understand and make decisions. During a review of Resident 77's MDS dated [DATE], the MDS indicated Resident 77 had severely impaired cognition and required substantial/maximal assistance with eating and total assistance from staff with all ADLs. During a review of Resident 77's fall risk assessments dated 7/10/2024, 10/9/2024, and 1/10/2025, the fall risk assessments indicated Resident 77 was a high risk for falls. During a review of Resident 77's care plan (CP) on at risk for falls related to gait or balance problems and incontinence initiated on 4/2/2024 and last revised on 4/13/2024, the CP indicated to be sure the resident's call light is within reach and encourage the resident to use for assistance as needed and the resident needs prompt response to all requests for assistance. During a review of Resident 77's Order Summary Report, the Order Summary Report indicated a physician's order dated 11/27/2024 for call light placed within reach. During a concurrent observation and interview on 2/14/2025 at 9:15 a.m. inside Resident 77's room with LVN 1, LVN 1 stated Resident 77's pad call light (a sensitive call light that enables patients with have difficulty activating standard call light to summon help easily) was placed on the upper left side of the bed and not within Resident 77's reach. LVN 1 stated before to leaving the room, the staff should make sure all residents' call light should be within reach. LVN 1 stated Resident 77 had limited movement of the upper extremities and unable to reach for the call light or move her head towards the call light to activate. LVN 1 stated Resident 77's call light should have been within reach so Resident 1 can call for assistance when needed and her needs attended promptly. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/17/2025 at 4:55 p.m. reviewed Resident 77's Order Summary Report, care plans, and fall risk assessments with the ADON. The ADON stated Resident 77's physician's order and care plan indicated to place call light reach and the fall risk assessments indicated Resident 77 was a high risk for falls. The ADON stated the staff should ensure all residents' call light is within reach prior to leaving the room so the residents can call for assistance and the staff can attend to their needs. The ADON stated Resident 77's call light should have been clipped to the sheet and within the resident's reach so the staff can attend and meet Resident 77's needs timely. During a review of the facility's P&P titled, Answering the Call Light, last reviewed on 1/14/2025, the P&P indicated the following: - When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. - Answer the resident's call as soon as possible.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38552 Based on interview and record review, the facility failed to inform and provide the resident/representative the option to formulate an advance directive (legal documents that provide instructions for medical care and only go into effect if the resident cannot communicate their wishes) for two of three sampled residents (Resident 20 and Resident 84) reviewed for Advance Directive care area. This deficient practice violated Resident 20 and Resident 84's rights and/or representatives' right to be fully informed of the option to formulate an advance directive. Findings: a. During a review of Resident 20's Admission Record, the Admission record indicated the facility originally admitted the resident on 8/22/2023 and readmitted on [DATE] with diagnoses including cardiomyopathy (a disease of the heart muscle that makes it harder for the heart to pump blood to the rest of the body), chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), and generalized muscle weakness. During a review of Resident 20's Internal Medicine Initial Evaluation, dated 1/24/2025, the evaluation indicated the resident had the capacity to understand and make decisions. During a review of Resident 20's Minimum Data Set (MDS - a resident assessment tool), dated 1/26/2025, indicated the resident had adequate hearing and clear speech, had the ability to make self understand and understand others. The MDS indicated Resident 20 was dependent on staff for shower/bathe self and required substantial/maximal assistance with upper and lower body dressing and putting on/taking off footwear. The MDS indicated Resident 20 was dependent on staff with mobility including sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer. During a concurrent interview and record review on 2/16/2025 at 1:29 p.m. with Social Services Director (SSD), Resident 20's Social Service Assessment, dated 1/23/2025, was reviewed. The Social Service Assessment indicated, under Advance Directive section, as not applicable. The SSD stated she did not offer and provide information to Resident 20 if they would like to formulate an advance directive or not. The SSD stated this is completed at the time of admission. The SSD stated when Resident 20 is not offered and provided an option to formulate an Advance Directive or not could affect his overall medical decisions and not follow his wishes and his after-life care. During an interview on 2/17/2025 at 5:55 p.m., the Director of Nursing (DON) stated the admission department starts the conversation with the Advance Directives. The DON stated then the SSD will do the assessment advance directive and quarterly and annually can be reviewed. The DON stated at the time of readmission the SSD and the admitting nurse will have to ask and validate if the resident/representative had executed an Advance Directive. The DON stated if they would like to formulate it then they will assist and discuss during the interdisciplinary meeting. The DON stated the resident's wishes would not be known unless it is in writing because it serves as a document to help the resident. The DON stated wishes can change in advance and it will help the providers navigate the resident's care and knows what the resident's wishes are. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Advance Directives last reviewed on 1/14/2025, the P&P indicated Upon admission, the resident will be provided with written information concerning the right to refuse to accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do . If the resident indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advances directives. a. The resident will be given the option to accept or decline the assistance, and care will not be contingent on either decision. b. Nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline assistance. 43878 b. During a review of Resident 84's Admission Record, the Admission Record indicated the facility admitted Resident 84 on 11/30/2024 and readmitted the resident on 12/23/2024 with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (partial paralysis or weakness on one side of the body) following a cerebral infarction (a medical condition that occurs when the blood flow to the brain is disrupted due to issues with the arteries that supply it) affecting the right dominant side, encephalopathy (brain damage or disease that affects the brain's structure or function), and aphasia (a language disorder that makes it difficult to communicate). The Admission Record indicated Resident 84 had a Resident Representative. During a review of Resident 84's History of Present Illness (H&P- a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 12/24/24, indicated Resident 84 could make needs known but cannot make medical decisions. During a review of Resident 84's Minimum Data Set (MDS - a resident assessment tool), dated 12/30/2024 indicated Resident 84 rarely had the ability to understand and rarely had the ability to be understood. The MDS indicated Resident 84 was dependent (helper does all the effort) on oral hygiene, toileting, showering, upper and lower body dressing, putting on and taking off footwear and personal hygiene. During a record review on 2/16/2025 at 8:25 a.m. of Resident 84's medical records (a history of someone's health), the medical records indicated there was no advance directive and/or advance directive acknowledgment noted in Resident 84's medical record. During a concurrent record review and interview on 2/16/2025 at 8:30 a.m. with Health Information Director (HID), Resident 84's chart was reviewed. The HID stated there was no documented evidence there was an Advance Directive Acknowledgment in the chart but would verify with Social Services Director (SSD). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/16/2025 at 8:42 a.m., the SSD stated upon admission residents are asked about Physician Orders for Life-Sustaining Treatment (POLST- a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life) and advance directive. The SSD stated there is no advance directive acknowledgment or any documentation to indicate Resident 84's responsible party was informed of formulating an advance directive. The SSD should be offering advance directives to residents as it is their right to have an advance directive and know what their wishes are. The SSD stated an advance directive is a paper form of the resident's after-life wishes. The SSD stated advance directives acknowledgment form has not been offered to Resident 84 and/or his responsible party with a risk for Resident 84's right not to be respected. During an interview on 2/17/2025 at 4:05 p.m., the Director of Nursing (DON) stated Resident 84 has been in the facility since November of last year. The DON stated that if advance directive information is not in the chart it means the SSD did not communicate and did not offer. During a review of the facility's policy and procedure (P&P) titled, Advance Directives, last reviewed 1/14/2025, the P&P indicated advance directives will be respected in accordance with state law and facility policy. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. If the resident is incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the resident's legal representative. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 43878 Based on interview and record review, the facility failed to follow its policy and procedure (P&P) titled, Change in a Resident's Condition or Status (COC), for one of two sampled residents (Resident 50) by not promptly informing Resident 50's resident representative when on 1/23/2025 Resident 50 had a laboratory result of low iron level (a condition where your body has too few iron stores). This deficient practice resulted to violation of Resident 50 or the resident representative's right to be notified. Findings: During a review of Resident 50's Admission Record, the Admission Record indicated the facility admitted Resident 50 on 1/10/2025 with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (partial paralysis or weakness on one side of the body) following a cerebral infarction (a medical condition that occurs when the blood flow to the brain is disrupted due to issues with the arteries that supply it) affecting the left dominant side, epilepsy (a chronic brain disorder that causes seizures, which are abnormal electrical discharges in the brain), and essential (primary) hypertension (HTN - high blood pressure). The Admission Record indicated Resident 50's family member was the resident representative. During a review of Resident 50's History and Physical (H&P) Note, dated 1/11/2025, the H&P indicated Resident 50 had fluctuating capacity to understand and make decisions. During a review of Resident 50's Minimum Data Set (MDS - a resident assessment tool), dated 1/17/2025, the MDS indicated Resident 50 had the ability to understand and had the ability to be understood. The MDS indicated Resident 50 was dependent (helper does all the effort) with toileting, showering, upper and lower body dressing, putting on and taking off footwear and personal hygiene. During a review of Resident 50's Lab Result Report, dated 1/23/2025, the report indicated an iron level of 49 micrograms per deciliter (ug/dL - a unit of measurement, normal range of 65 to 175 ug/dL). The result indicated Resident 50's iron level was low. During a review of Resident 50's Progress Notes, dated 1/23/2025 at 2:07 p.m., the notes indicated labs were relayed to Nurse Practitioner (NP- a registered nurse with advanced training who provides patient care). During a review of Resident 50's Order Summary Report, dated 1/23/2025, the report indicated an order for ferrous sulfate (a type of iron that treats and prevents iron deficiency anemia) 325 milligrams (mg- a unit of measurement), to give one tablet by mouth three times a day for supplement with meals to prevent stomach upset. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review and interview on 2/16/2025 at 3:07 p.m. with the Health Information Director (HID), Resident 50's Situational Background Assessment and Recommendation (SBAR - a structured way to share information between people, especially in healthcare setting), was reviewed. The HID stated there were no SBARs done on 1/23/2025 for Resident 50. During a concurrent record review and interview on 2/17/2025 at 11:37 a.m. with Minimum Data Set Coordinator Nurse (MDSC), Resident 50's medical records (a history of someone's health) were reviewed. The MDSC stated a SBAR is for any change in a resident's condition, it can be for a decline or improvement for all aspects of care mental and physical. The MDSC stated an abnormal laboratory would require a SBAR to be done. The MDSC reviewed Resident 50's labs on 1/23/2025 and stated Resident 50's iron is low. The MDSC stated there should be a SBAR for the low iron labs but does not see a SBAR for the low iron result. The MDSC stated the purpose of a SBAR is to have interventions, must call the doctor, there needs to be monitoring, care planning and contact the family and/or resident representative. The MDSC stated did not see any specific monitoring or care plan for the low iron for Resident 50. The MDSC stated monitoring would include to observe for tarry stools, skin color, and bleeding. The MDSC stated the risk of not doing a SBAR is failing to notify the family of the COC since it is their right to know so that they can be informed and make regarding Resident 50's care. The MDSC stated also a risk for no interventions for monitoring a potential risk for internal bleeding and distress. The MDSC stated since there was no SBAR created, there was no care plan created to monitor sign and symptoms of anemia, because the care plans are to establish interventions and monitoring for effectiveness. During a concurrent record review and interview on 2/17/2025 at 4:17 p.m. with the Director of Nursing (DON), Resident 50's medical records were reviewed. The DON stated a SBAR is used to do an assessment to identify the change in a resident, must notify the doctor to review the plan of care and revised accordingly. The DON stated an SBAR is for any changes in residents that are off baseline. The DON reviewed Resident 50's labs on 1/23/2025 and stated iron level of 49 ug/dL was low reflecting a change in Resident 50's labs and would require for the nurse to do an SBAR. The DON stated with a SBAR staff will ask additional questions, and will include monitoring, and the doctor may order follow up labs. The DON stated there was no follow up order for labs after low iron results. The DON stated Resident 50 would require a care plan for low iron level. The DON stated Resident 50 must have a care plan to have a direction of treatment and how to address the situation. The DON stated the low iron level was not relayed to family. The DON stated it may have violated the family member's right to be informed of the COC. During a review of the facility's P&P titled, Change in a Resident's Condition or Status, last reviewed 1/14/2025, the P&P indicated our facility promptly notifies the resident, his or her attending physician, and the resident representatives of changes in the resident's medical and or mental conditions and or status. The nurse will record in the resident's medical record information relative to changes in the resident's medical and mental condition or status. If a significant change in the resident's physical or mental condition occurs, a comprehensive assessment of the resident condition will be conducted as required by current OBRA regulation governing resident assessments and as outline in the MDS RAI instruction Manual.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 43878 Based on observation, interview, and record review, facility failed to maintain privacy of confidential information when Licensed Vocational Nurse 4 (LVN 4) left the electronic health record (EHR- a digital version of a patient's paper chart) opened, unattended and out of view for one of one sampled resident (Resident 92) during a random observation. This deficient practice violated Resident 92's right to privacy and confidentiality of their medical records. Findings: During a review of Resident 92's Admission Record, the Admission Record indicated the facility admitted Resident 92 on 1/30/2025 with diagnoses including personal history of transient ischemic attack (TIA- a temporary disruption of blood flow to the brain), essential (primary) hypertension (HTN-high blood pressure), and hyperlipidemia (high levels of fat, or lipids, in the blood). During a review of Resident 92's Minimum Data Set (MDS - a resident assessment tool) dated 2/3/2025, the MDS indicated Resident 92 had the ability to understand and be understood. During an observation on 2/15/2025 at 10:02 a.m. observed LVN 4 standing outside of Resident 92 room with EHR opened to Resident 92's medication administration records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident). Observed LVN 4 then walk away to Nurse Station 2 away from the computer leaving Resident 92's EHR open. During an interview on 2/15/2025 at 10:08 a.m. with LVN 4, LVN 4 stated she left Resident 92's EHR opened and unattended. LVN 4 stated she should have closed the computer as there is a risk for someone to have access to Resident 92's personal information that they should not have access to. During an interview on 2/17/2025 at 4:28 p.m. with the Director of Nursing (DON), the DON stated staff must minimize the computer screen when walking away from the computer to protect resident information. The DON stated there is a potential for someone to pass by and other people to see resident information who should not have access to the residents' records. During a review of the facility's policy and procedures (P&P) titled, Confidentiality of Information and Personal Privacy, last reviewed 1/14/2025, the P&P indicated the facility will protect and safeguard resident confidentiality and personal privacy. The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records. Access to resident personal and medical records will be limited to authorized staff and business associates.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 43988 Based on observation, interview, and record review, the facility failed to provide a safe, comfortable, and homelike environment for one (1) of three (3) sampled residents (Resident 32) reviewed under Environmental Task by failing to ensure Resident 32's right floor mat was not torn off on the right lower corner. This deficient practice had the potential to negatively affect the resident's quality of life. Findings: During a review of Resident 32's Admission Record, the Admission Record indicated the facility originally admitted the resident on 1/24/2025 with diagnoses including muscle wasting and atrophy (loss of muscle mass and strength), dementia (a progressive state of decline in mental abilities), and generalized muscle weakness. During a review of Resident 32's History and Physical (H&P) dated 10/16/2024, the H&P indicated Resident 32 did not have the capacity to understand and make decisions. During a review of Resident 32's Minimum Data Set (MDS, a resident assessment tool), dated 12/15/2025, the MDS indicated Resident 32 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required supervision or touching assistance with eating; total assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 32's Order Summary Report, the Order Summary Report indicated a physician's order dated 11/26/2024 for floor mat (landing mat) on the right side of the bed and monitor every shift for proper positioning and placement. During a review of Resident 32's care plan (CP) on risk for falls and injuries initiated on 5/18/2021 and last revised on 2/3/2025, the CP indicated floor mat (landing mat) on the right side of the bed and monitor for proper positioning and placement every shift as one of the interventions to prevent falls. During a concurrent observation and interview on 2/15/2025 at 9:18 a.m. inside Resident 32's room with Treatment Nurse 1 (TN 1), TN 1 stated Resident 32's right floor mat had the right lower corner torn off. TN 1 stated the maintenance department will be notified to change the floor mat. TN 1 stated the staff are responsible to notify the maintenance department if a resident equipment needs to be changed in the room. TN 1 stated Resident 32's torn floor mat was not providing a homelike environment for the resident. TN 1 stated the facility is considered Resident 32's home already and had to be provided a clean, safe, and functioning equipment in the room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/17/2025 at 4:55 p.m. with the Assistant Director of Nursing (ADON), the ADON stated if staff observed any equipment, devices, or furnishing in the room that is in disrepair such as the floor mat that is torn, the maintenance department should be notified immediately to change the device, equipment, or furnishings. The ADON stated residents are provided with a safe, clean, functioning equipment, furnishings while residing in the facility as the facility is already their home. The ADON stated Resident 32's floor mat should have been changed as soon as observed with the torn off right lower corner to provide a homelike environment for the resident as it can affect Resident 32's wellbeing while in the facility. During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, last reviewed 6/27/2024, the P&P indicated: - Residents are provided with a safe, clean, comfortable and homelike environment. - The facility staff and management maximizes, to the extent possible the characteristics of the facility that reflect a personalized, homelike setting such as a clean, safe, sanitary and orderly/clutter free environment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 38552 Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity including the right to be free from physical restraints (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body) for one of one sampled resident (Resident 20) reviewed for physical restraints care area by failing to ensure Resident 20 had an informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered), a restraint assessment, and a care plan for restraint bed placed against the wall. These deficient practices had the potential to result in the restriction of resident's freedom of movement, a decline in physical functioning, psychosocial harm, and physical harm from entrapment (a state in which a person is trapped by the bed rail in a position that they cannot move from). Findings: During a review of Resident 20's Admission Record, the Admission Record indicated the facility originally admitted the resident on 8/22/2023 and readmitted the resident on 1/22/2025 with diagnoses including cardiomyopathy (a disease of the heart muscle that makes it harder for the heart to pump blood to the rest of the body), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and generalized muscle weakness. During a review of Resident 20's Internal Medicine Initial Evaluation, dated 1/24/2025, the Internal Medicine Initial Evaluation indicated the resident has the capacity to understand and make decisions. During a review of Resident 20's physician's order dated 2/13/2025, the physician's order indicated devices: left one fourth (1/4) side rail (bar or barrier that attaches to the side of a bed) and right side of bed towards the wall for enabler and resident's preference. During a review of Resident 20's Minimum Data Set (MDS-a resident assessment tool), dated 1/26/2025, the MDS indicated the resident had adequate hearing and clear speech, had the ability to make self understood and understand others. The MDS indicated the resident was dependent on staff for shower/bathe self and required substantial/maximal assistance with upper and lower body dressing and putting on/taking off footwear. The MDS indicated the resident was dependent on staff with mobility including sit to lying, lying to sitting on side of bed, sit to stand, and chair/bed-to-chair transfer. During an observation on 2/15/2025 at 10:07 a.m., Resident 20 was lying asleep on a low bed. The right side of Resident 20's bed was up against the wall. During an interview on 2/15/2025 at 12:45 p.m. with Resident 20, Resident 20 stated his right side of his bed had been up against the wall for a long time since he was admitted and readmitted . Resident 20 stated he does not know why his right side of the bed was up against the wall and would prefer his bed not to be that close to the wall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 2/16/2025 at 2:37 p.m. with Certified Nursing Assistant (CNA 6) inside Resident 20's room, Resident 20's right side of bed was up against the wall. CNA 6 stated Resident 20 was asleep on bed. CNA 6 stated since Resident 20 had been admitted , the resident's bed had always been up against the wall. CNA 6 stated he (CNA 6) assumes it was because the resident was high risk for falls, but he was unsure of the exact reason. CNA 6 stated if Resident 20 needed to transfer out of bed, he (CNA 6) would assist the resident on the left side of the bed. During a concurrent observation and interview on 2/16/2025 at 2:44 p.m. with Licensed Vocational Nurse (LVN 7), Resident 20's right side of his bed was up against the wall. Resident 20 was asleep on the bed. LVN 7 stated she did not know why the resident's bed was up against the wall. During an interview on 2/16/2025 at 3:26 p.m. with the MDS Coordinator (MDSC), the MDSC stated restraint assessment, informed consent, interdisciplinary meeting, physician orders, and care plan are done on admission or when it (restraint) is used and reviewed at least quarterly. The MDSC stated restraints prohibit the movement of the resident. During a concurrent interview and record review on 2/16/2025 at 3:36 p.m. with the MDSC, reviewed Resident 20's physician orders, assessments, informed consent, and care plans. The MDSC stated there was no restraint assessment, no informed consent, and no care plan on the use of restraint bed placed against the wall. The MDSC stated it is important to have all the requirements in place to ensure the restraint was safe to be used and for the staff to know what interventions to implement for the resident. The MDSC stated at a minimum, restraint use should be evaluated quarterly. During an interview on 2/17/2025 at 6:04 p.m. with the Director of Nursing (DON), the DON stated there is a physician's order for Resident 20's preference of having the right side of bed up against the wall. The DON stated that the freedom of movement includes being able to get out of bed on the right side of the bed. The DON stated Resident 20 is unable to move the bed away from the wall. The DON stated they will reassess all residents whose bed is up against the wall using their facility's policy and procedure (P&P) titled, Use of Restraints. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Use of Restraints last reviewed on 1/14/2025, the P&P indicated Restraints shall only used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented. The P&P indicated 1. 'Physical Restraints' are defined as any manual method or physical or mechanical device . or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. The deficient of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which the staff applied it given that resident's physical condition (i.e., side rails are put back fown, rather than climbed over), and this restricts his/her typical ability to change position or place, that device is considered a restraint . Residents and/or surrogate/sponsor shall be informed about the potential risks and benefits of all options under consideration, including the use of restraints, not using restraints, and the alternatives to restraint use . Care plans for residents in restraints will reflect interventions that address not only the immediate medical symptom(s), but the underlying problems that may be causing the symptom(s). Care plans shall also include the measures taken to systematically reduce or eliminate the need for restraint use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on interview and record review, the facility: 1. Failed develop a comprehensive person-centered care plan (CP-a document outlining a detailed approach to care customized to an individual resident's needs) timely for one of one sampled resident (Resident 2) reviewed for anticoagulant (blood thinner - prevents blood clots or keep an existing clot from getting worse) when Resident 2's care plan addressing the use of heparin (anticoagulant) was developed 25 days after readmission. 2. Failed to develop a comprehensive person-centered care plan for one of two sampled residents (Resident 50) reviewed for Change of Condition (COC) care area when Resident 50 had a COC of low iron laboratory results (too low may be a sign of anemia [lack of oxygen-rich blood which can cause fatigue, weakness, and dizziness]) on 1/23/2025. These deficient practices had the potential for a delay in providing the necessary care and treatments to Residents 2 and 50. Findings: a. During a review of Resident 2's Admission Record, the Admission Record indicated the facility originally admitted Resident 2 on 2/8/2021 and readmitted the resident on 12/27/2024, with diagnoses including dementia (a progressive state of decline in mental abilities), contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of muscle on multiple sites, and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 1/18/2025, the MDS indicated Resident 2 had severely impaired cognition (having the ability to think, learn, and remember clearly) and required total assistance with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident received anticoagulant. During a re view of Resident 2's History and Physical (H&P) dated 12/30/2024, the H&P indicated Resident 22 did not have the capacity to understand and make decisions. During a review of Resident 2's Order Summary Report, the Order Summary Report indicated a physician's order dated 12/27/2024 for heparin sodium (porcine) injection solution 5000 units per milliliter (units/ml - a unit of measurement) **dispense as written ([NAME])** 5000 units hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) two (2) times a day for blood clot prevention. During a review of Resident 2' care plan (CP) on risk for bleeding or bruising related to use of heparin, the CP indicated it was initiated on 1/21/2025. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/16/2025 at 2:45 p.m., reviewed Resident 2's physician's order and CP with Registered Nurse 1 (RN 1). RN 1 stated Resident 2 had a physician's order for heparin dated 12/27/2024 and the care plan was initiated on 1/21/2025. RN 1 stated care plans are supposed to be initiated as soon as a physician's order was received. RN 1 stated Resident 2's care plan addressing the use of heparin should have been initiated timely on 12/27/2025 so everyone involved in Resident 2's care would be aware of the proper interventions needed to prevent delay in providing the necessary care and treatment Resident 2 needed. During a concurrent interview and record review on 2/17/2025 at 4:19 p.m., reviewed Resident 2's physician's order and care plan with the Assistant Director of Nursing (ADON). The ADON stated care plans, especially new medication orders, should be initiated by the nurse who received the order. The ADON stated Resident 2 had a physician's order dated 12/27/2025 for heparin and the care plan addressing the use of heparin was developed and implemented on 1/21/2025. The ADON stated Resident 2's care plan addressing the use of heparin was not developed and implemented timely. The ADON stated Resident 2's care plan for the heparin should have been developed and implemented timely on 12/27/2025 so the other disciplines involved in the care of Resident 2 would be aware of the interventions to prevent delay in providing care and treatment for the resident. During a review of the facility's policy and procedure (P&P) titled, Care Plan, Comprehensive Person-Centered, last reviewed on 1/2025, the P&P indicated: - A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident - The comprehensive person-centered care plan is developed within seven (7) days of completion of the required comprehensive assessment (MDS). - The comp person-centered care plan will: a. include measurable objectives and timeframes. b. describe the services that are to be furnished to attain or maintain the resident's highest practicable, mental, and psychosocial well-being. 43878 b. During a review of Resident 50's Admission Record, the Admission Record indicated the facility admitted Resident 50 on 1/10/2025 with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (partial paralysis or weakness on one side of the body) following a cerebral infarction (a medical condition that occurs when the blood flow to the brain is disrupted due to issues with the arteries that supply it) affecting the left dominant side, epilepsy (a chronic brain disorder that causes seizures, which are abnormal electrical discharges in the brain), and essential (primary) hypertension (HTN-high blood pressure). During a review of Resident 50's History and Physical (H&P) Note dated 1/11/2025, the H&P Note indicated Resident 50 had fluctuating capacity to understand and make decisions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 50's Minimum Data Set (MDS - a resident assessment tool), dated 1/17/2025, the MDS indicated Resident 50 was able to make self understood and understand others. The MDS indicated Resident 50 was dependent (helper does all the effort) with toileting, showering, upper and lower body dressing, putting on and taking off footwear, and personal hygiene. During a review of Resident 50's Laboratory Result Report dated 1/23/2025, the Laboratory Result Report indicated an iron level of 49 micrograms per deciliter (ug/dL-a unit of measurement, normal range 65-175 ug/dL); the result indicated the iron level was low. During a review of Resident 50's Progress Notes dated 1/23/2025 at 2:07 p.m., the Progress Notes indicated the laboratory results were relayed to the Nurse Practitioner (NP- a registered nurse with advanced training who provides patient care) with new orders carried out. During a review of Resident 50's Order Summary Report dated 1/23/2025, the Order Summary Report indicated a physician's order for ferrous sulfate (a type of iron that treats and prevents iron deficiency anemia) 325 milligrams (mg- a unit of measurement) give 1 tablet by mouth three times a day for supplement with meals to prevent stomach upset. During a concurrent record review and interview on 2/17/2025 at 11:37 a.m. with the Minimum Data Set Coordinator Nurse (MDSC) of Resident 50's medical records (a history of someone's health), the MDSC stated she did not see a care plan for Resident 50's low iron. The MDSC stated no care plan was created to indicate monitoring for signs and symptoms of anemia. The MDSC stated care plans are used to establish interventions which included monitoring for effectiveness as there is also a risk for constipation when taking iron. During a concurrent record review and interview on 2/17/2025 at 4:17 p.m. of Resident 50's medical records with the Director of Nursing (DON), the DON stated Resident 50 would require a care plan for low iron. The DON stated having a care plan provides the direction of treatment and how to address the situation. During a review of the facility's policy and procedure (P&P) titled, Care Plan, Comprehensive Person-Centered, last reviewed on 1/2025, the P&P indicated: - A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident - The comprehensive person-centered care plan is developed within seven (7) days of completion of the required comprehensive assessment (MDS). - The comp person-centered care plan will: a. include measurable objectives and timeframes. b. describe the services that are to be furnished to attain or maintain the resident's highest practicable, mental, and psychosocial well-being.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 42311 Based on interview and record review, the facility failed to revise the comprehensive care plan for one of five sampled residents (Resident 32) reviewed for unnecessary medications by failing: 1. To revise (update) Resident 32's care plan on the use of bupropion (medication used to treat depression [a common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest in activities once enjoyed]) after the physician increased the dose of the medication on 12/19/2024. 2. To ensure care plans reflect the updated interventions provided to Resident 32. These deficient practices had the potential for delayed provision of necessary care and services. Findings: During a record review of Resident 32's Admission Record, the Admission Record indicated the facility admitted Resident 32 on 5/17/2021, with diagnoses that included including type two (2) diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing), metabolic encephalopathy (a condition where the brain does not function properly due to an underlying metabolic imbalance), generalized muscle weakness, and dementia (a progressive state of decline in mental abilities). During a record review of Resident 32's History and Physical (H&P - a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 10/16/2024, the H&P indicated Resident 32 did not have the capacity to understand and make decisions. During a record review of Resident 32's Minimum Data Set (MDS - a resident assessment tool), dated 12/15/2024, the MDS indicated Resident 32's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 32 required supervision or touching assistance with eating and total assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 32 was on antidepressant (medications used to treat symptoms of depression) and insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication). A. During a record review of Resident 32's Physician Order, dated 12/19/2024, the Physician Order indicated the following order: 1. Bupropion hydrochloride extended release, give 150 milligrams (mg - metric unit of measurement, used for medication dosage and/or amount) by mouth one time a day for depression manifested by lack of motivation with activities of daily living. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Discontinue bupropion hydrochloride extended release, 100 mg by mouth one time a day for depression manifested by lack of motivation with activities of daily living. During a concurrent interview and record review on 2/16/2025, at 2:34 p.m., with the Assistant Director of Nursing (ADON), Resident 32's Care Plan on bupropion use, dated 9/27/2023, was reviewed. The ADON stated the facility last updated the care plan for bupropion use on 9/27/2023 and the facility did not revise the comprehensive care plan on 12/19/2024 when the physician increased the dose of the medication from 100 mg to 150 mg. The ADON stated Resident 32's care plan should have been updated when medication is increased. The ADON stated the importance of updating or revising the care plan was to guide nurses on medication administration. During an interview on 2/17/2025 at 1:49 p.m. with the Director of Staff Development (DSD), the DSD stated Resident 32's care plan should have been updated for any medication increase or any medication change. During an interview on 2/17/2025, at 4:17 p.m. with the Minimum Data Set Nurse (MDSC), the MDSC stated the MDS nurses updates and revises the care plan quarterly (every three months). The MDSC stated if medication was increase, the staff who received the order should revise the care plan. The MDSC stated Licensed Vocational Nurses (LVNs) should have revised the care plan on Resident 32's use of bupropion. The MDSC stated the importance of revising Resident 32's care plan was to guide nurses on the latest order and intervention for the resident. During an interview on 2/17/2025, at 5:13 p.m. with the Director of Nursing (DON), the DON stated Resident 32's care plan should have been revised with any medication changes and if medication dose was increased to give an actual presentation of what the intervention so staff can monitor the effect of the medication. During a record review of facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 12/2016, and last reviewed on 1/14/2025, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implement for each resident. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents condition change. The interdisciplinary team must review and update the care plan . b. when the desired outcome is not met. 43988 B. During a review of Resident 32's Order Summary Report, the Order Summary Report indicated the following physician's orders: 1. 2/12/2024: Lantus solution (a long-acting insulin [a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication])100 unit per milliliter (unit/ml - a unit of measurement) inject 34 units subcutaneously (beneath the skin) at bedtime related to DM 2. Hold if blood sugar (BS) is less than (<) 100. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. 1/24/2025: Novolog solution (a short acting insulin)100 unit/ml (insulin aspart) inject as per sliding scale (increasing administration of the pre?meal insulin dose based on the blood sugar level before the meal): <60, hypoglycemic protocol and inform physician (MD); if 60 - 149 = 0 unit;150 - 199 = 2 units; 200 - 249 = 4 units; 250 - 299 = 6 units; 300 - 349 = 8 units; 350 - 399 = 10 units; 400 plus = 12 unit; more than (>) 400, 12 units and inform MD subcutaneously with meals for DM. During a review of Resident 32's care plan (CP) on DM initiated in 5/23/2021 and last revised on 2/9/2023, the CP indicated the following interventions: 1. Humalog solution 100 unit/ml (Insulin Lispro - a short acting insulin) inject as per sliding scale: if 60 - 149 = 0 Unit < 60, hypoglycemic protocol and inform MD.; 150 - 199 = 2 units; 200 - 249 = 4 units; 250 - 299 = 6 units; 300 - 349 = 8 units; 350 - 399 = 10 units; 400 plus = 12 Units; if > 400, 12 Units and inform MD., subcutaneously before meals and at bedtime 2. Diabetes medications (insulin lispro, glargine) as ordered by doctor. Monitor/document for side effects and effectiveness. 3. Humalog Solution 100 unit/ml (insulin lispro) inject four (4) units subcutaneously three times a day 4. Lantus solution 100 unit/ml (insulin glargine) inject 20 units subcutaneously at bedtime. During a concurrent interview and record review on 2/17/2025 at 4:20 p.m., Resident 32's CP on DM 2 was reviewed with the Assistant Director of Nursing (ADON). The ADON stated Resident 32's CP interventions for the insulin were not updated to reflect the current dose the physician ordered. The ADON stated care plans are updated during the quarterly or annual MDS assessments and as needed when a new order is received. The ADON stated Resident 32's should have been updated when the order was changed to reflect the current type of insulin and dosage ordered by the physician so everyone would be aware of Resident 32's current plan of care to prevent delay in the delivery of necessary services the resident needed. During a review of the facility's policy and procedure (P&P) titled, Goals and Objectives, Care Plans, last reviewed on 1/14/2025, the P&P indicated care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence. The P&P further indicated: - Care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence. - When goals and objective are not achieved, the resident's clinical record will be documented why the results were not achieved and what new goals and objectives have been established. Care plans will be modified accordingly. - Goals and objectives are entered on the resident's care plan so that all disciplines have access to such information and are able to report whether or not the desired outcomes are achieved. - Goals and objectives are reviewed and/or revised: a. When there has been a change in the resident's condition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. When the desired outcome has not been achieved.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on interview and record review, the facility failed to provide care in accordance with professional standards: 1. For one of one sampled resident (Resident 32) reviewed for insulin (a hormone that lowers the level of glucose [a type of sugar] in the blood) by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (beneath the skin) the insulin administration sites. This deficient practice had the potential for adverse effect (unwanted, unintended result) of same site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). 2. For one of one sampled resident (Resident 2) reviewed for anticoagulant (commonly called blood thinner, that increase the time it takes for blood to clot) by failing to ensure there was monitoring in place for signs and symptoms of bleeding for the use of heparin (an anticoagulant). This deficient practice had the potential to cause Resident 2 unintended complications related to the side effects (unwanted, unpleasant results of a medication) of anticoagulant use such as bleeding or bruising if not monitored routinely which may lead to hospitalization or even death. Cross Reference F760 (Resident 32) and F755 (Resident 2) Findings: a. During a review of Resident 32's Admission Record, the Admission Record indicated the facility originally admitted the resident on 1/24/2025 with diagnoses including type two (2) diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing), dementia (a progressive state of decline in mental abilities), and generalized muscle weakness. During a review of Resident 32's History and Physical (H&P) dated 10/16/2024, the H&P indicated Resident 32 did not have the capacity to understand and make decisions. During a review of Resident 32's Minimum Data Set (MDS, a resident assessment tool), dated 12/15/2025, the MDS indicated Resident 32 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required supervision or touching assistance with eating; total assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS further indicated Resident 32 received insulin. During a review of Resident 32's Order Summary Report, the Order Summary Report indicated the following physician's orders dated: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 2/12/2024: Lantus solution (a long-acting insulin [a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication])100 unit per milliliter (unit/ml - a unit of measurement) inject 34 units subcutaneously (beneath the skin) at bedtime related to DM 2. Hold (do not administer) if blood sugar (BS) is less than (<) 100. - 1/7/2025: Lantus solution 100 unit/ml (insulin glargine) inject 26 units subcutaneously at bedtime related to DM 2. Hold if BS <100. - 12/8/2024: Lantus solution 100 unit/ml (insulin glargine) inject 26 units subcutaneously at bedtime related to DM 2. - 10/14/2024 to 1/24/2025: Novolog solution (a short acting insulin)100 unit/ml (insulin aspart) inject as per sliding scale (increasing administration of the pre?meal insulin dose based on the blood sugar level before the meal): <60, hypoglycemic (low blood sugar) protocol and inform physician (MD); if 60 - 149 = 0 unit;150 - 199 = 2 units; 200 - 249 = 4 units; 250 - 299 = 6 units; 300 - 349 = 8 units; 350 - 399 = 10 units; 400 plus = 12 unit; more than (>) 400, 12 units and inform MD subcutaneously before meals and at bedtime for DM 2. - 1/24/2025: Novolog solution 100 unit/ml (insulin aspart) inject as per sliding scale: <60, hypoglycemic protocol and inform physician (MD); if 60 - 149 = 0 unit;150 - 199 = 2 units; 200 - 249 = 4 units; 250 - 299 = 6 units; 300 - 349 = 8 units; 350 - 399 = 10 units; 400 plus = 12 unit; > 400, 12 units and inform MD subcutaneously with meals for DM 2. During a concurrent interview and record review on 2/16/2025 at 2:22 p.m., reviewed Resident 32's physician's orders, Medication Administration Record (MAR - a daily documentation records used by a licensed nurse to document medications and treatments given to a resident) Location of Administration Report for 1/2025 and 2/2025 with Licensed Vocational Nurse 1 (LVN 1). LVN 1 stated Resident 32 had a physician's order for Novolog and Lantus and were administered as follows: - Lantus solution 100 unit/ml: 1/13/25 10:45 p.m. subcutaneously Abdomen - left upper quadrant (LUQ) 1/14/25 9:14 p.m. subcutaneously Abdomen - LUQ 2/12/25 9:40 p.m. subcutaneously Abdomen - right upper quadrant (RUQ) 2/13/25 9:11 p.m. subcutaneously Abdomen - RUQ - Novolog solution 100 unit/ml: 1/02/25 9:00 p.m. subcutaneously Abdomen - left lower quadrant (LLQ) 1/03/25 5:45 a.m. subcutaneously Abdomen - LLQ 1/15/25 8:55 p.m. subcutaneously Abdomen - LUQ 1/16/25 6:27 a.m. subcutaneously Abdomen - LUQ (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/16/25 11:53 a.m. subcutaneously Abdomen - RUQ 2/03/25 8:55 p.m. subcutaneously Abdomen - RUQ 2/04/25 9:01 p.m. subcutaneously Abdomen - RUQ 2/11/25 9:02 p.m. subcutaneously Abdomen - LUQ 2/12/25 9:40 p.m. subcutaneously Abdomen - LUQ 2/13/25 9:13 p.m. subcutaneously Abdomen - LUQ 2/14/25 8:29 p.m. subcutaneously Abdomen - LUQ 2/07/25 4:21 p.m. subcutaneously Abdomen - right lower quadrant (RLQ) 2/08/25 8:42 a.m. subcutaneously Abdomen - RLQ 2/08/25 1:15 p.m. subcutaneously Abdomen - RLQ 2/15/25 7:47 a.m. subcutaneously Abdomen - LUQ 2/15/25 12:10 p.m. subcutaneously Abdomen - LUQ 2/16/25 7:39 a.m. subcutaneously Abdomen - LUQ 2/16/25 11:26 a.m. subcutaneously Abdomen - LUQ LVN 1 stated insulin administration sites should be rotated per standards of practice, manufacturer's guidelines, and according to physician's orders. LVN 1 stated the last three (3) administration sites for insulin was shown every time the staff opens the MAR. LVN 1 stated Resident 32's MAR indicated the insulin administration sites were not rotated. LVN 1 stated Resident 32's insulin administration sites should have been rotated per standards of practice to prevent pain, redness, irritation, bruising, and pits on the resident's skin. During a concurrent interview and record review on 2/17/2025 at 4:30 p.m., reviewed Resident 32's physician's orders, MAR Location of Administration Report for 1/2025 and 2/2025 with the Assistant Director of Nursing (ADON). The ADON stated the locations of administration sites for Resident 32's insulin were not rotated. The ADON stated the charge nurses (CN) are supposed to rotate insulin administration sites according to standards of practice and as indicated in the manufacturer's guideline and the CN can see the last 3 administration sites of insulin in the MAR. The ADON stated Resident 32's administration sites for insulin should have been rotated to prevent adverse effects such as bruising, skin irritation, skin pits, lipodystrophy and amyloidosis which can affect absorption of the insulin. During a review of the facility-provided manufacturer's guideline on Lantus insulin glargine injection 100 unit/ml, undated, the manufacturer's guideline indicated: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Change (rotate) the injection sites within the area chosen with each dose to reduce the risk of getting lipodystrophy (pitted or thickened skin) and localized cutaneous amyloidosis skin with lumps) at the injection sites. - Do not use the same spot for each injection or inject where the skin is pitted, thickened, lumpy, tender, bruised, scaly, hard, or damaged. During a review of the facility-provided manufacturer's guideline on Insulin aspart (vials) (Novolog), undated, the manufacturer's guideline indicated: - Move site where you give the shot each time. - It is given as a shot into the fatty part of the skin in the upper arm, buttocks, or stomach area. - A side effect include thick skin pits, or lumps where the injection was given. - Do not give into skin that is thickened, or has pits, or has lumps. - Do not into skin that is irritated, tender, bruised, red, scaly, hard, scarred. During a review of the facility policy and procedure (P&P) titled, Insulin administration, last reviewed on 1/14/2025, the P&P indicated: - Select an injection site: a. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately two (2) inches above the navel. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). b. During a review of Resident 2's Admission Record, the Admission Record indicated the facility originally admitted Resident 2 on 2/8/2021 and readmitted the resident on 12/27/2024, with diagnoses including dementia (a progressive state of decline in mental abilities), contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of muscle on multiple sites, and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had severely impaired cognition (having the ability to think, learn, and remember clearly) and required total assistance with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident received anticoagulant. During a re view of Resident 2's History and Physical (H&P) dated 12/30/2024, the H&P indicated Resident 22 did not have the capacity to understand and make decisions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 2's Order Summary Report, the Order Summary Report indicated a physician's order dated 12/27/2024 for heparin sodium (porcine) injection solution 5000 units per milliliter (units/ml - a unit of measurement) **dispense as written ([NAME])** 5000 units hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) two (2) times a day for blood clot prevention. During a review of Resident 2's care plan (CP) on anticoagulant therapy (heparin) initiated on 1/21/2025, the CP indicated the following interventions to prevent adverse reactions related to anticoagulant use: - Daily skin inspection. Report abnormalities to the nurse. - Monitor/document/report as needed adverse reaction of anticoagulant therapy: blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, bruising, significant or sudden changes in vital signs. During a concurrent interview and record review on 2/16/2025 at 2:45 p.m., reviewed Resident 2's physician's orders and MAR with Registered Nurse 1 (RN 1). RN 1 stated Resident 2 did not have a physician's order to monitor for bleeding every shift for the use of anticoagulant heparin. RN 1 stated residents should have a physician's order to monitor residents for signs and symptoms of bleeding due to use of anticoagulant. RN 1 stated there should have been a physician's order to monitor Resident 2 for signs and symptoms of bleeding as it placed Resident 32 at risk for untoward cardiac (pertaining to the heart) events and hospitalization . During a concurrent interview and record review on 2/17/2025 at 4:19 p.m., reviewed Resident 2's physician's order and MAR with the Assistant Director of Nursing (ADON). The ADON stated Resident 2 did not have a physician's order to monitor the resident for signs of symptoms of bleeding and there was no monitoring for bleeding in the MAR. The ADON stated the licensed nurse (LN) should also obtain a physician's order for monitoring for signs and symptoms of bleeding every shift along with the order for anticoagulant per facility protocol. The ADON stated the LN should have obtained an order for monitoring for signs and symptoms of bleeding addressing Resident 2's use of heparin to prevent complications related to not monitoring the symptoms of bleeding which may lead to hospitalization . During a review of the facility's policy and procedure (P&P titled, Anticoagulant - Clinical Protocol, last reviewed 1/14/2025, the P&P indicated: - Assess for any signs and symptoms related to adverse drug reactions due to the medication alone or in combination with other medications. - Assess for evidence of effects related to the subtherapeutic or greater than therapeutic drug level related to that particular drug) for example, a resident with an above therapeutic level of an anticoagulation medication should be assessed for bleeding. - The nurse shall assess and document or report the current anticoagulant therapy, including drug and current dosage. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Long-term subcutaneous administration of heparin in chronically bed-bound individuals is not indicated or of proven benefit for long-term deep vein thrombosis (DVT - a blood clot that forms in the veins located deep within a limb, usually the lower leg or thigh) prophylaxis. - The staff and physician will monitor for possible complications in individuals who are being anticoagulated and will manage related problems. a. If an individual on anticoagulation therapy shows signs of excessive bruising, or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose. During a review of the facility's P&P titled, Standards of Clinical Practice, last reviewed 1/14/2025, the P&P indicated a policy statement that services provided to the residents are performed in accordance with current acceptable standards of clinical practice.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43878 Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 67) reviewed for nutrition care area was provided with the care and services to maintain good nutrition by failing to provide Resident 67 with assistance with all meals as the physician has ordered. This deficient practice had the potential for Resident 67 to lose weight and/or be malnourished (not getting enough of the right nutrients from food). Findings: During a review of Resident 67's Admission Record, the Admission Record indicated the facility admitted Resident 67 on 3/22/2024 and readmitted the resident on 12/6/2024 with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (partial paralysis or weakness on one side of the body) following a cerebral infarction (a medical condition that occurs when the blood flow to the brain is disrupted due to issues with the arteries that supply it) affecting the left dominant side, muscle weakness, moderate protein calorie malnutrition (a nutritional condition that occurs when someone doesn't get enough protein and calories), and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 67's Nutritional assessment dated [DATE], the Nutritional Assessment indicated Resident 67 was on puree diet texture upon readmission, recently upgraded per Speech Therapy; resident needs assistance with meals; and oral (PO) intake were mostly 25-75 percent (%). During a review of Resident 67's Order Summary Review, the Order Summary Review indicated the following physician's orders dated 12/6/2024: - Regular diet mechanical soft texture. Regular liquid consistency, fortified meals, four ounces (oz-unit of measurement), high protein nourishment (HPN) with meals. - Provide feeding assistance at all times. During a review of Resident 67's Nutritional assessment dated [DATE], the Nutritional Assessment indicated resident needs assistance with meals with PO intakes mostly 25-75%. During a review of Resident 67's Minimum Data Set (MDS - a resident assessment tool), dated 12/12/2024, the MDS indicated Resident 67 had the ability to understand and be understood. The MDS indicated Resident 67 was dependent (helper does all the effort) with toileting, showering, lower body dressing, putting on and taking off shoes, and required partial assistance (helper does less than half the effort) oral hygiene, upper body dressing, and personal hygiene. During a review of Resident 67's care plan created on 1/17/2025 for nutritional and dehydration (the body doesn't have enough water in it to function properly), the care plan indicated interventions that included to assist resident as needed with feeding and to monitor for signs of malnutrition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 67's Speech Therapy Evaluation and Plan of Treatment dated 2/13/2025, the Speech Therapy Evaluation and Plan of Treatment indicated Resident 67 requires supervision and/or assistance with meals 91-100% of the time due to swallow safety. During a review of Resident 67's progress notes dated 2/15/2025 at 3:24 p.m., the progress notes indicated Resident 67 refused to eat breakfast. The progress notes also indicated Resident 67 consumed 50% of lunch when his family assisted Resident 67 with feeding. During a review of the facility's Nursing Staffing Assignment and Sign-in Sheet dated 2/16/2025 for the 7-3 shift and 3-11 shift, the Nursing Staffing Assignment and Sign-in Sheet indicated Resident 67 was not listed as a resident that required assistance with meals. During an interview on 2/15/2025 at 2:30 p.m. with Resident 67's Family Member 1 (FM 1), FM 1 stated Resident 67 would benefit from someone assisting the resident with meals as Resident 67 was not able to feed himself and staff do not help him toeat. During a concurrent observation and interview on 2/15/2025 at 6:38 p.m. with the Director of Rehab (DOR), observed Resident 67 sitting up on bed with the bedside table in front of him. Observed the resident's food tray on the bedside table that contained a cup of spilled water. The DOR stated Resident 67 eats independently but after seeing Resident 67's tray, the DOR asked Resident 67 if he needed assistance with feeding. During an observation and interview on 2/15/2025 at 6:55 p.m., observed Certified Nursing Assistant 7 (CNA 7) sitting on a chair next to Resident 67 assisting the resident with his meal. CNA 7 stated Resident 67 is requiring a lot of assistance and cueing. During an observation on 2/16/2025 at 7:22 a.m., observed Resident 67 sitting up with tray in front of him. There was no staff assisting Resident 67 with his meal. During a concurrent observation and interview on 2/16/2025 at 7:54 a.m. with Treatment Nurse 1 (TN 1) of Resident 67's breakfast tray, TN 1 stated Resident 67 may have eaten two bites of his breakfast. During an interview on 2/16/2025 at 4:46 p.m. with CNA 2, CNA 2 stated there is a list on their work assignments that indicate which residents require assistance with their meals. During an interview on 02/17/25 at 10:02 a.m. with CNA 3, CNA 3 stated she has been assisting Resident 67 with meals because the resident has not been eating by himself. CNA 3 stated Resident 67 used to eat on his own, but he needs encouragement. CNA 3 stated now, staff must assist Resident 67 with feeding himself. CNA 3 stated Resident 67 consumed 90% of breakfast that day because the resident had assistance with feeding himself. CNA 3 stated the list of residents who require assistance with meals is indicated in their assignment. CNA 3 stated Resident 67's name was not indicated on the list. During an interview on 02/17/25 at 10:16 a.m. with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated Resident 67 needs assistance with meals and the assignment will reflect the resident's name. LVN 4 stated Resident 67 requires assistance with eating, if CNAs are not assisting Resident 67 with meals, he will not eat and will have his tray in front of him untouched. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/17/2025 at 5:12 p.m. with the Director of Nursing (DON), the DON stated the charge nurses (LVNs) are the ones who inform the CNAs on who are the residents requiring assistance with meals. The DON stated the Occupational Therapist (OT) should be able to communicate to staff that Resident 67 requires more assistance. The DON stated Resident 67 required verbal cues and the resident was able to follow commands. The DON stated the physician's order indicated to provide feeding assistance to Resident 67 at all times. The DON stated this means staff should be assisting the resident with all meals. The DON stated if Resident 67 is not provided assistance with feeding, the resident might not eat which can place the resident at risk for weight loss and weakness. During a review of the facility's policy and procedures (P&P) titled, Activities of Daily living (ADLs), Supporting, last reviewed 1/14/2025, the P&P indicated residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. During a review of the facility's P&P titled, Dining and or Assistance with Meals, last reviewed 1/14/2025, the P&P indicated resident shall receive assistance with meals in a manner that meets the individual needs of each resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 43878 Based on interview and record review, the facility failed to ensure that one of two residents (Resident 50) reviewed for Change of Condition (COC) care area received treatment and care in accordance with professional standards of practice when a Situational, Background, Assessment, and Recommendation (SBAR-a structured way to share information between people, especially in healthcare setting) was not created for Resident 50 when the resident had a COC of low iron laboratory results (too low may be a sign of anemia [lack of oxygen-rich blood which can cause fatigue, weakness, and dizziness]) on 1/23/2025. This deficient practice had the potential for Resident 50 to go unmonitored for low iron resulting in the potential for fatigue, weakness, and dizziness. Findings: During a review of Resident 50's Admission Record, the Admission Record indicated the facility admitted Resident 50 on 1/10/2025 with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (partial paralysis or weakness on one side of the body) following a cerebral infarction (a medical condition that occurs when the blood flow to the brain is disrupted due to issues with the arteries that supply it) affecting the left dominant side, epilepsy (a chronic brain disorder that causes seizures, which are abnormal electrical discharges in the brain), and essential (primary) hypertension (HTN-high blood pressure). During a review of Resident 50's History and Physical (H&P) Note dated 1/11/2025, the H&P Note indicated Resident 50 had fluctuating capacity to understand and make decisions. During a review of Resident 50's Minimum Data Set (MDS - a resident assessment tool), dated 1/17/2025, the MDS indicated Resident 50 was able to make self understood and understand others. The MDS indicated Resident 50 was dependent (helper does all the effort) with toileting, showering, upper and lower body dressing, putting on and taking off footwear, and personal hygiene. During a review of Resident 50's Laboratory Result Report dated 1/23/2025, the Laboratory Result Report indicated an iron level of 49 micrograms per deciliter (ug/dL-a unit of measurement, normal range 65-175 ug/dL); the result indicated the iron level was low. During a review of Resident 50's Progress Notes dated 1/23/2025 at 2:07 p.m., the Progress Notes indicated the laboratory results were relayed to the Nurse Practitioner (NP- a registered nurse with advanced training who provides patient care) with new orders carried out. During a review of Resident 50's Order Summary Report dated 1/23/2025, the Order Summary Report indicated a physician's order for ferrous sulfate (a type of iron that treats and prevents iron deficiency anemia) 325 milligrams (mg- a unit of measurement) give 1 tablet by mouth three times a day for supplement with meals to prevent stomach upset. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review and interview on 2/16/2025 at 3:07 p.m. with the Health Information Director (HID) of Resident 50's SBAR, the HID stated there was no SBAR created on 1/23/2025 for Resident 50. During a concurrent record review and interview on 2/17/2025 at 11:37 a.m. with the Minimum Data Set Coordinator Nurse (MDSC) of Resident 50's medical records (a history of someone's health), the MDSD stated an SBAR is intended for any change in a resident's condition which can be either a decline or improvement in all aspects of care. The MDSC stated an abnormal laboratory result would require an SBAR to be done. The MDSC reviewed Resident 50's laboratory result on 1/23/2025 and stated Resident 50's iron was low. The MDSC stated there should be an SBAR created addressing Resident 50's low iron level. The MDSC stated the purpose of an SBAR is to have interventions like informing the doctor, monitoring the resident, and contacting the family and/or resident representative. The MDSC stated Resident 50's monitoring would include observing for tarry stools, skin color, and bleeding. During a concurrent record review and interview on 2/17/2025 at 4:17 p.m. of Resident 50's medical records with the Director of Nursing (DON), the DON stated an SBAR is used to do an assessment to identify the change of condition in a resident and to allow the facility to notify the doctor. The DON reviewed Resident 50's laboratory result on 1/23/2025 and stated the resident's iron level of 49 ug/dL was low and would require for the nurse to do an SBAR. The DON stated having an SBAR will guide the nurse to ask additional questions and will include monitoring the resident. The DON stated if Resident 50 was diagnosed with anemia, the facility would do monitoring for fatigue. During a review of the facility's policy and procedures (P&P) titled, Quality of Care, last reviewed 1/14/2025, the P&P indicated each resident shall be cared for in a manner that promotes and enhances quality of care. Resident-centered care can be provided that responds to individual preference, needs, and values. During a review of the facility's P&P titled, Change in a Resident's Condition or Status, last reviewed 1/14/2025, the P&P indicated the facility promptly notifies the resident, his or her attending physician, and the resident representatives of changes in the resident's medical and/or mental conditions and/or status. The nurse will record in the resident's medical record information relative to changes in the resident's medical and mental condition or status.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43878 Based on observation, interview and record review, the facility failed to ensure five of six sampled residents (Resident 23, Resident 92, Resident 95, Resident 297, and Resident 32) reviewed for accident care area were free of accidents when: 1. Resident 23's pathway to the bathroom (restroom/toilet) was obstructed with his roommate's wheelchair. This deficient practice had the potential for Resident 23 to fall while waiting to get into the bathroom. 2. Resident 92's acetaminophen (pain medication) two tablets and enoxaparin (treats and prevents blood clots) were left on top of the medication cart unattended and out of the sight of Licensed Vocational Nurse 4 (LVN 4). This deficient practice had the potential for Resident 92's medications to be taken by another resident or other person. 3. The facility failed to accurately document Resident 95's Fall Risk Assessment after Resident 95 had a fall. This deficient practice had the potential for Resident 95 to have inaccurate assessment of fall that can affect nursing interventions. 4. The facility failed to ensure Resident 297's and 32's floor mat (a cushioned mat that reduces the risk of injury from a fall) did not have a furniture or equipment on top of them. This deficient practice increased the risk of injury when the residents slip, trip, and fall by hitting the hard surface of the equipment or furniture on top of the floor mat. Findings: a. During a review of Resident 23's Admission Record, the Admission Record indicated the facility admitted Resident 23 on 8/14/2024 and readmitted the resident on 9/16/2024 with diagnoses that included acquired absence of right below the knee, muscle wasting and atrophy (decrease in size or wasting away of a body part or tissue) multiple sites, and muscle weakness. During a review of Resident 23's Care Plan created on 8/14/2025 for risk for fall and injuries, the care plan indicated interventions that included assess and anticipate resident's needs and ensure personal items within resident reach. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 23's Bowel (the long, tube-shaped organ in the abdomen that completes the process of digestion) and Bladder (a hollow, stretchy organ in the lower part of your abdomen that stores urine before it leaves your body through your urethra) assessment dated [DATE], the Bowel and Bladder Assessment indicated Resident 23 was continent (the ability to control your bladder and bowel) with both bowel and bladder. During a review of Resident 23's Care Plan created 8/23/2024, the Care Plan indicated Resident 23 was at risk for incontinency due to aging process and medical conditions with limited mobility. The interventions included to ensure the resident has unobstructed path to the bathroom. During a review of Resident 23's Minimum Data Set (MDS - a resident assessment tool), dated 11/18/2024, the MDS indicated Resident 23 had the ability to understand and be understood. The MDS indicated Resident 23 required partial assistance (helper does less than half the effort) with toileting, lower body dressing, and putting on and taking off footwear. During a review of Resident 23's Quarterly Risk assessment dated [DATE], the Quarterly Risk Assessment indicated Resident 23 had a fall risk score of 10 (a total score of 10 or above represents high risk for fall). During an interview on 2/15/2025 at 9:33 a.m. with Resident 23, Resident 23 stated staff place his roommate's wheelchair locked and blocking the bathroom door making him unable to use the bathroom. During a concurrent observation and interview on 2/16/2025 at 11:18 a.m. with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated a wheelchair was blocking the bathroom. LVN 4 stated because Resident 23 is independent with using the bathroom, the front door to the bathroom should be clear to allow for Resident 23 to safely use the restroom. LVN 4 stated Resident 23 may have a fall trying to get to the restroom. LVN 4 moved the wheelchair to the side of the roommate's bed to clear the entrance to the restroom. During a concurrent observation and interview on 2/17/2025 at 7:31 a.m. with Certified Nursing Assistant 4 (CNA 4), CNA 4 stated Resident 23's roommate's wheelchair left by the night shift staff was blocking the bathroom door. CNA 4 stated the area leading to the bathroom should be clear for Resident 23 to be able to use the restroom and the resident can fall trying to get into the bathroom. During an interview on 2/17/2025 at 4:48 p.m. with the Director of Nursing (DON), the DON stated staff must move all obstruction (including the wheelchair) to allow Resident 23 to safely get in and out of the bathroom. During a review of the facility's policy and procedures (P&P) titled, Safety and Supervision of Residents, last reviewed 1/14/2025, the P&P indicated the facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. During a review of the facility's P&P titled, Homelike environment, last reviewed 1/14/2025, the P&P indicated residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belonging to the extent possible. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Accommodation of Needs, last reviewed 1/14/2025, the P&P indicated the facility's environment and staff behaviors are directed toward assisting the resident in maintaining and or achieving a safe independent functioning, dignity and well-being. f. moving furniture or large items in rooms and common areas that may obstruct the path of a resident. b. During a review of Resident 92's Admission Record, the Admission Record indicated the facility admitted Resident 92 on 1/30/2025 with diagnoses including personal history of transient ischemic attack (TIA- a temporary disruption of blood flow to the brain), essential (primary) hypertension (HTN-high blood pressure), and hyperlipidemia (high levels of fat, or lipids, in the blood). During a review of Resident 92's MDS dated [DATE], the MDS indicated Resident 92 had the ability to understand and be understood. During a review of Resident 92's Order Summary dated 1/30/2025, the Order Summary indicated the following physician's orders: - Acetaminophen tablet 325 milligram (mg- a unit of measurement) give two tablets by mouth every six hours as need for mild pain (rated 1 to 3 out of 10 [with 10 as severe pain]) not to exceed 3 grams (gm- a unit of measurement) in 24 hours. - Enoxaparin sodium injection solution 40 mg/4 milliliters (ml- a unit of measurement) inject 40 mg subcutaneously (beneath or under the skin) one time a day for deep vein thrombosis (DVT- is a blood clot that forms in a deep vein, usually in the leg, thigh, or pelvis) prevention. During a review of Resident 92's Care Plan created on 2/5/2025, the Care Plan indicated the use of enoxaparin with interventions to monitor for signs and symptoms of neurological impairment, and if neurological compromise is noted, urgent treatment is necessary. During a review of Resident 92's Care Plan created on 2/5/2025, the Care Plan indicated a risk for bleeding and/or bruising related to the use of lovenox (enoxaparin) with interventions to administer medication per doctor's order. During an observation on 2/15/2025 at 10:02 a.m., observed LVN 4 standing outside of Resident 92's room with enoxaparin and a medication cup containing two pills on top of the medication cart. Observed LVN 4 walking away from the medication cart with enoxaparin and two pills on top medication cart left unattended while LVN 4 went to Nurses Station 2. During an interview on 2/15/2025 at 10:08 a.m. with LVN 4, LVN 4 stated she left Resident 92's medication that included two acetaminophen tablets and enoxaparin on top of the medication cart unattended and out of her sight. LVN 4 stated should not be leaving medications unattended as there can be a potential for someone to take the medications. During an interview on 2/17/2025 at 4:54 p.m. with the DON, the DON stated medications should not be left on top of the medication cart and out of the sight of the nurse. The DON stated but there is always a potential for a resident to grab the medications. The DON stated the best practice is to lock medications when leaving the medication cart. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Administering Medications, last reviewed 1/14/2025, the P&P indicated during administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. It may be kept in the doorway of the resident's room, with open drawers facing inward and all other sides closed. No medications are kept on top of the cart. The cart must be clearly visible to the personal administering medications, and all outward side must be inaccessible to residents or others passing by. c. During a review of Resident 95's Admission Record, the Admission Record indicated the facility admitted the resident on 12/11/2024 with diagnoses that included muscle weakness (generalized), reduced mobility, lack of coordination, and acquired absence of left leg above knee. During a review of Resident 95's MDS dated [DATE], the MDS indicated Resident 95 usually understands and was usually understood. The MDS indicated Resident was dependent (helper does all the effort) with toileting, showering, lower body dressing and putting on and taking off footwear and required substantial assistance (helper does more than half the effort) with eating, oral hygiene, upper body dressing, and personal hygiene. During a review of Resident 95's Admission and Readmission Initial assessment dated [DATE], the Admission and Readmission Initial Assessment indicated a fall risk score of 10 (a total score of 10 or above represents high risk for fall). During a review of Resident 95's Care Plan created on 12/12/2024, the Care Plan indicated the resident was at risk for falls and injuries related to balance problems, gait abnormality, poor trunk control, and bowel and bladder incontinence. The Care Plan interventions included the resident needs activities that minimize the potential for falls while providing diversion and distraction. During a review of Resident 95's Situational Background Assessment and Request (SBAR- a structured way to share information between people, especially in healthcare setting) dated 12/28/2024 at 7:49 p.m., the SBAR indicated Resident 95 was noted on the floor by his bed, on his right side of the body. Resident 95 stated he was turning in his bed and then he fell . During a review of Resident 95's Care Plan created on 12/28/2024 for actual unwitnessed fall with no injury, the Care Plan interventions included to assess and anticipate resident's needs and continue the at-risk plan. During a review of Resident 95's Fall Risk assessment dated [DATE], the Fall Risk Assessment indicated a score of 8 (not a high risk for a fall). During an interview on 2/17/2025 at 12:01 p.m. with the Minimum Data Set Nurse Coordinator (MDSC), the MDSC stated Resident 95's initial fall risk score was 10 indicating Resident 95 was a high risk for a fall. The MDSC stated on 12/28/2024, Resident 95's fall risk indicated a score of 8 (lower risk for falls). The MDS stated the fall risk assessment should have indicated a higher score (or the same score but not lower) after Resident 95's falls. The MDSC stated proper interventions and precautions may not be done as a result of the inaccurate fall risk assessment. The MDSC stated Resident 95 continued to have intermittent confusion and should not have been documented as alert. The MDSC stated Resident 95's fall risk score should have been an 11. 43988 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. During a review of Resident 297's Admission Record, the Admission Record indicated the facility originally admitted Resident 297 on 5/7/2024 and readmitted in the facility on 2/12/2025, with diagnoses including congestive heart failure (CHF - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), dementia (a progressive state of decline in mental abilities), and generalized weakness. During a review of Resident 297's History and Physical, dated 2/13/2025, the H&P indicated the resident can make his needs known but unable to make medical decisions. During a review of Resident 297's Admission/Readmission Initial Assessment form dated 2/12/2025, the Admission/Readmission Initial Assessment form indicated Resident 297 required supervision/touching assistance with eating; partial/moderate assistance with bed mobility; substantial/maximal assistance with toileting hygiene; all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive) were not tested due to safety concerns. During a review of Resident 297's fall risk assessment dated [DATE], the fall risk assessment indicated the resident was not a high risk for falls. During a concurrent observation and interview on 2/15/2025 at 8:45 a.m., inside Resident 297's room with Certified Nursing Assistant 5 (CNA 5), CNA 5 stated Resident 297's overbed table was placed on top of the right floor mat for unknown amount of time. CNA 5 stated the overbed table wheels left an indentation on the floor mat and was unstable when she tried to move it (overbed table). CNA 5 stated the overbed table can fall on Resident 297 and cause injury to the resident. CNA 5 further stated Resident 297 can hit the table, loose balance, and cause injury upon getting out of bed. CNA 5 stated the overbed table should not have been left on top of the floor mat as it placed Resident 297 at risk for getting hurt during a fall. During an interview on 2/17/2025 at 4:30 p.m., with the Assistant Director of Nursing (ADON), the ADON stated there should be no heavy equipment or any furniture on top of the floor mat as it can affect the integrity of the floor mat which could affect the impact of a fall incident. The ADON stated placing any equipment or furniture on top of the floor mat can cause injury when the resident get up and hit the table due to unstable balance, or the overbed table can be unstable and fall on the resident when moved. The ADON stated Resident 297's overbed table should not have been placed on top of the floor mat as it placed Resident 297 at risk for incurring injury in case of a fall. During a review of the facility's recent P&P titled Safety and Supervision of Residents last reviewed on 1/14/2025, the P&P indicated safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; quality assurance and performance improvement (QAPI, a data driven and proactive approach to quality improvement of care) reviews of safety and incident/accident data; and facility-wide commitment to safety. During a review of the facility-provided user instruction for Floor Mat 1 (FM 1), undated, the user instruction indicated in addition to low height beds that have been found to help reduce the incidence of falls; impact reduction fall mats placed alongside the bed have become a cost-effective means to help reduce the incidence of patient trauma and severity of injury by providing a cushioned, slide resistant surface. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. During a review of Resident 32's Admission Record, the Admission Record indicated the facility originally admitted the resident on 1/24/2025 with diagnoses including muscle wasting and atrophy (loss of muscle mass and strength), dementia (a progressive state of decline in mental abilities), and generalized muscle weakness. During a review of Resident 32's History and Physical (H&P) dated 10/16/2024, the H&P indicated Resident 32 did not have the capacity to understand and make decisions. During a review of Resident 32's MDS dated [DATE], the MDS indicated Resident 32 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required supervision or touching assistance with eating; total assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 32's fall risk assessments dated 6/17/2024, 9/20/2024, and 12/18/2024, the fall risk assessments indicated the resident was a high risk for falls. During a review of Resident 32's care plan (CP) on risk for falls and injuries related to gait/balance problems and dementia initiated on 5/18/2021 and last revised on 2/3/2025, the CP indicated floor mat (landing mat) on the right side of the bed and monitor for proper positioning and placement every shift as one of the interventions to prevent falls. During a concurrent observation and interview on 2/15/2025 at 9:18 a.m. inside Resident 32's room with Treatment Nurse 1 (TN 1), TN 1 stated Resident 32's overbed table was placed on top of the right floor mat and was unstable when moved and the wheels left an indentation on the floor mat. TN 1 stated the overbed table can be unstable and fall on Resident 32 when moved or the resident can hit the table when Resident 32 accidentally rolls out of the beds and cause injury. TN 1 stated the overbed table should not have been placed on top of the floor mat as it placed Resident 32 at risk for injuries during a fall or any incident. During an interview on 2/17/2025, at 4:30 p.m., with the ADON, the ADON stated there should be no heavy equipment or any furniture on top of the floor mat as it can affect the integrity if the floor mat which could affect the impact of a fall or incident. The ADON placing any equipment or furniture on top of the floor mat can cause injury when the residents get up and hit the table due to unstable balance or the overbed table can be unstable and fall on the resident when moved. The ADON stated Resident 32's overbed table should not have been placed on top of the floor mat as it placed Resident 32 at risk for incurring injury in case of a fall. During a review of the facility's recent P&P) titled Safety and Supervision of Residents last reviewed on 1/14/2025, the P&P indicated safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QAPI reviews of safety and incident/accident data; and facility-wide commitment to safety. During a review of the facility-provided user instruction for Floor Mat 1 (FM 1), undated, the user instruction indicated in addition to low height beds that have been found to help reduce the incidence of falls; impact reduction fall mats placed alongside the bed have become a cost-effective means to help reduce the incidence of patient trauma and severity of injury by providing a cushioned, slide resistant surface.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43878 Based on observation, interview, and record review, the facility failed to provide acceptable parameter of nutrition for one of two sampled residents (Resident 67) reviewed under nutrition when: 1. Resident 67's medical doctor (MD) was not informed when the resident ate less than 50% for two consecutive meals on: - 2/10/2025 for lunch and dinner - 2/13/2025 for lunch and dinner - 2/14/2025 refused breakfast and has less than 50% of lunch 2. Resident 67 was not provided assistance with meals on: - 2/15/2025 dinner and - 2/16/2025 breakfast and lunch . These deficient practices had the potential for Resident 67 to lose weight and/or be malnourished (not enough of the right nutrients from food). Findings: During a review of Resident 67's Admission Record, the Admission Record indicated the facility admitted Resident 67 on 3/22/2024 and readmitted the resident on 12/6/2024 with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (partial paralysis or weakness on one side of the body) following a cerebral infarction (a medical condition that occurs when the blood flow to the brain is disrupted due to issues with the arteries that supply it) affecting the left dominant side, muscle weakness, moderate protein calorie malnutrition (a nutritional condition that occurs when someone doesn't get enough protein and calories), and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 67's Nutritional assessment dated [DATE], the Nutritional Assessment indicated Resident 67 was on puree diet texture upon readmission, recently upgraded per Speech Therapy; resident needs assistance with meals; and oral (PO) intake were mostly 25-75 percent (%). During a review of Resident 67's Order Summary Review, the Order Summary Review indicated the following physician's orders dated 12/6/2024: - Regular diet mechanical soft texture. Regular liquid consistency, fortified meals, four ounces (oz-unit of measurement), high protein nourishment (HPN) with meals. - Provide feeding assistance at all times. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 67's Nutritional assessment dated [DATE], the Nutritional Assessment indicated resident needs assistance with meals with PO intakes mostly 25-75%. During a review of Resident 67's Minimum Data Set (MDS - a resident assessment tool), dated 12/12/2024, the MS indicated Resident 67 had the ability to understand and be understood. The MDS indicated Resident 67 was dependent (helper does all the effort) with toileting, showering, lower body dressing, putting on and taking off shoes, and required partial assistance (helper does less than half the effort) oral hygiene, upper body dressing, and personal hygiene and required set-up assistance (helper sets up or cleans up) with eating. During a review of Resident 67's care plan created on 1/17/2025 for nutritional and dehydration (the body doesn't have enough water in it to function properly), the care plan indicated interventions that included to assist resident as needed with feeding and to monitor for signs of malnutrition. During a review of Resident 67's care plan created on 2/4/2025, the care plan indicated resident has potential nutritional problem and dehydration risk related to recent poor PO intake less than 50%. The care plan interventions included to provide/serve diet as ordered, record intake per meal, report intake below 50%. During a review of Resident 67's Situational Background Assessment and Request (SBAR- a communication framework that helps people share information in a structured way) dated 2/12/2025 at 1:55 p.m., the SBAR indicated Resident 67 was noted with cough during drinking liquids. During lunch, resident was noted with coughing during fluid intake. There were no choking or excessive coughing noted at that time. During a review of Resident 67's Speech Therapy Evaluation and Plan of Treatment dated 2/13/2025, the Speech Therapy Evaluation and Plan of Treatment indicated Resident 67 requires supervision and/or assistance with meals 91-100% of the time due to swallow safety. During a review of Resident 67's progress notes dated 2/15/2025 at 3:24 p.m., the progress notes indicated Resident 67 refused to eat breakfast. The progress notes also indicated Resident 67 consumed 50% of lunch when his family assisted Resident 67 with feeding. During a review of the facility's Nursing Staffing Assignment and Sign-in Sheet dated 2/16/2025 for the 7-3 shift and 3-11 shift, the Nursing Staffing Assignment and Sign-in Sheet indicated Resident 67 was not listed as a resident that required assistance with meals. During an interview on 2/15/2025 at 2:30 p.m. with Resident 67's Family Member 1 (FM 1), FM 1 stated Resident 67 would benefit from someone assisting the resident with meals as Resident 67 was not able to feed himself and staff do not help him to eat. During an observation and interview on 2/15/2025 at 6:55 p.m., observed Certified Nursing Assistant 7 (CNA 7) sitting on a chair next to Resident 67 assisting the resident with his meal. CNA 7 stated Resident 67 is requiring a lot of assistance and cueing. During an observation on 2/16/2025 at 7:22 a.m., observed Resident 67 sitting up with tray in front of him. There was no staff assisting Resident 67 with his meal. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 2/16/2025 at 7:54 a.m. with Treatment Nurse 1 (TN 1) of Resident 67's breakfast tray, TN 1 stated Resident 67 may have eaten two bites of his breakfast. During an interview on 2/16/2025 at 4:46 p.m. with CNA 2, CNA 2 stated there is a list on their work assignments that indicate which residents require assistance with their meals. During an interview on 02/17/25 at 10:02 a.m. with CNA 3, CNA 3 stated she has been assisting Resident 67 with meals because the resident has not been eating by himself. CNA 3 stated Resident 67 used to eat on his own, but he needs encouragement. CNA 3 stated now, staff must assist Resident 67 with feeding himself. CNA 3 stated Resident 67 consumed 90% of breakfast that day because the resident had assistance with feeding himself. CNA 3 stated the list of residents who require assistance with meals is indicated in their assignment. CNA 3 stated Resident 67's name was not indicated on the list. CNA 3 stated if a resident refuses to eat, they (CNAs) were told to try and offer meal three times, and if the resident still refused, they (CNAs) notify the charge nurse. During a concurrent record review of Resident 67's Care Plan for the potential for nutritional problem and dehydration risk related to recent poor PO intake less than 50% and Amount Eaten for February 2025 and interview on 02/17/25 at 10:16 a.m. with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated if a resident refuses to eat, they (staff) will offer nourishment or nutritional supplements ordered. LVN 4 stated if the resident refuses again, they must do an SBAR, start monitoring the resident, call the resident's MD, and inform the resident's family. LVN 4 stated Resident 67 needs assistance with meals and the assignment will reflect the resident's name. LVN 4 stated if a resident has had more than two meal refusals, they inform the resident's MD. LVN 4 reviewed Resident 67' Care Plan for potential nutritional problem and dehydration risk related to recent poor PO intake less than 50%, LVN 4 stated Resident 67's care plan indicated to report when Resident 67 eats less than 50%. LVN 4 stated the intervention should have been more specific to indicate how many meals are less than 50%. LVN 4 stated the intervention should have indicated to notify MD when resident eats less than 50% for two consecutive meals. LVN 4 reviewed Resident 67's Amount Eaten for February, LVN 4 stated Resident 67's meal consumption of less than 50% on consecutive meals for 2/10/2025, 2/13/2025, and 2/14/2025 should have been reported to the MD. LVN 4 stated those should have been reported to the MD so the MD can provide orders like laboratory tests, fluids, diet change, and/or medications. LVN 4 stated if the MD is not notified, there can be a risk for Resident 67 to lose weight and to be malnourished which can affect the resident's skin, hydration, and level of consciousness. During an interview on 2/17/2025 at 5:12 p.m. with the Director of Nursing (DON), the DON stated the LVNs should have reported Resident 67's meal consumption of less than 50% on consecutive meals for 2/10/2025, 2/13/2025, and 2/14/2025 to the MD for orders as there can be a risk for delay in care. The DON also stated if residents are eating less than usual, the CNAs communicate to the charge nurses. The DON stated Resident 67's consumption of two consecutive meals of 50% less would be concerning. During a review of the facility's policy and procedures (P&P) titled, Activities of Daily living (ADLs), Supporting, last reviewed 1/14/2025, the P&P indicated residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Dining and or Assistance with Meals, last reviewed 1/14/2025, the P&P indicated resident shall receive assistance with meals in a manner that meets the individual needs of each resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 42311 Based on interview and record review, the facility failed to provide necessary behavioral health care and services for one of five sampled residents (Resident 78) when the facility failed to conduct a behavioral interdisciplinary team (IDT - a coordinated group of experts from several different fields who work together) meeting on the use of Seroquel (an antipsychotic medication used to treat several kinds of mental health conditions) and escitalopram (medication used to treat depression [a common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest in activities once enjoyed]). This deficient practice had the potential to negatively affect the delivery of services. Findings: During a record review of Resident 78's Admission Record, the Admission Record indicated the facility admitted Resident 78 on 3/29/2024, with diagnoses that included other toxic encephalopathy (a condition where the brain becomes damaged due to the presence of toxins), unspecified (unconfirmed) dementia (a progressive state of decline in mental abilities) and depression. During a record review of Resident 78's Care Plan about use of antidepressant (medication used to treat depression), dated 3/29/2024, the Care Plan indicated an intervention to discuss with the Physician, family, the ongoing need for use of medication. During a record review of Resident 78's Care Plan about use of psychotropic medications (medications used to treat mental health conditions), dated 3/29/2024, the Care Plan indicated an intervention to discuss with the Physician, family the ongoing need for use of medication. During a record review of Resident 78's History and Physical (H&P - a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 3/30/2024, the H&P indicated, Resident 78 can make needs known but cannot make medical decisions. During a record review of Resident 78's Psychoactive Summary Sheet dated 12/1/2024 to 1/31/2024, for Seroquel, the Psychoactive Summary Sheet indicated from 12/1/2024 to 12/31/2024, Resident 78 had six behavioral episodes from 7:00 a.m. to 3:00 p.m. and six behavioral episodes from 11:00 p.m. to 7:00 a.m. The Psychoactive Summary Sheet indicated from 1/1/2025 to 1/31/2025, Resident 78 had two behavioral episode from 7:00 a.m. to 3:00 p.m. and two episodes from 11:00 p.m. to 7:00 a.m. During a record review of Resident 78's Minimum Data Set (MDS - a resident assessment tool), dated 1/6/2025, the MDS indicated Resident 78's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. During a record review of Resident 78's Physician Order, dated 1/23/2025, the Physician Order indicated the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Seroquel tablet, give 25 milligrams (mg - metric unit of measurement, used for medication dosage and/or amount) by mouth in the evening for psychotic disorder secondary to post traumatic stress disease (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event) manifested by striking out, resisting care and continuous screaming. 2. Escitalopram oxalate tablet 10 mg, give one tablet by mouth in the afternoon for depression manifested by social isolation (lack of social connection or support from others). During a record review of Resident 78's Behavior Management Meeting (a gathering to discuss and plan how to address a resident's behavior), dated 12/2/2024 and 2/3/2025, the Behavior Management Meeting did not indicate if Resident 78's use of antidepressant and psychotropic medication was discussed. During an interview, on 2/16/2025, at 6:46 p.m., with the Assistant Director of Nursing (ADON), the ADON stated the facility just started Behavioral IDT for residents on psychotropic medications on 12/2024 and not all residents on psychotropic medications was reviewed. During a concurrent interview and record review, on 2/17/2025, at 8:09 a.m., with the ADON, the ADON stated Resident 78's IDT was reviewed. The ADON stated the facility lacked documentation of Behavior Management Meeting (IDT) with Resident 78's Psychiatrist. The ADON stated the importance of an IDT with the Psychiatrist was to discuss if Resident 78 had increasing or decreasing behavior, so the Psychiatrist can adjust the medication to make sure Resident 78 is getting the correct dosage of the medication. During an interview, on 2/17/2025, at 1:43 p.m., with the Director of Staff Development (DSD), the DSD stated Behavioral IDT is important so the facility and the Psychiatrist can determine if resident needed medication adjustment or discontinuation. During an interview, on 2/17/2025, at 2:43 p.m., with the Director of Nursing (DON), the DON stated the Psychiatrist comes and visit every two months. The DON stated the ADON was in charge of the Behavioral IDT with the Psychiatrist. During an interview, on 2/17/2025, at 5:13 p.m., with the DON, the DON stated Behavioral IDT is a tool to monitor the effectiveness of the medication under the supervision of the clinician. During a record review of facility's policy and procedure (P&P) titled, Psychotropic/Antipsychotic Medications and Gradual Drug Dose Reduction, dated 4/2024 and last reviewed on 1/14/2025, the P&P indicated, Residents who use antipsychotic drugs shall receive gradual dose reduction and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Periodically, the staff and practitioner will review the continued relevance of each residents' medications. The attending Physician and staff will identify target symptoms for which a resident is receiving various medications. The staff will monitor for improvement in those target symptoms and provide the Physician with that information. During a record review of facility's policy and procedure (P&P) titled, Behavioral Health Services, dated 2/2019 and last reviewed on 1/14/2025, the P&P indicated, Behavioral health services are provided to residents as needed as part of the interdisciplinary, person-centered approach to care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42311 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) for five of nine sampled residents (Residents 25, 32, 41, 58, and 2) by failing: 1. To ensure Resident 25's Trelegy (a medication used to treat chronic obstructive pulmonary disease [COPD-a chronic lung disease causing difficulty in breathing] and asthma [a chronic lung disease that makes breathing difficult in adult]) and two over-the-counter multidose medications were labeled with dates the medications were opened for two of four medication carts reviewed. 2. To ensure Resident 32's physician order was followed. On 2/16/2025 at 7:43 a.m., LVN 1 administered Norco (medication used to treat pain) to Resident 32 with a pain level of zero. 3. To accurately document Resident 41's Medication Count Sheet for clonazepam (a medication that treats seizures and can also treat a panic disorder). 4. To ensure Resident 58's physician order was followed for potassium (a mineral that your body needs to work properly) administration. 5. To ensure there was monitoring in place for Resident 2 for signs and symptoms of bleeding for the use of heparin (an anticoagulant that prevent blood clots or keep an existing clot from getting worse). These deficient practices had the potential for medication errors and to not give the necessary care and services to the affected residents. Findings: a. During a concurrent medication administration observation and interview on 2/15/2025, at 8:16 a.m., with Licensed Vocational Nurse 3 (LVN 3), outside Resident 25's room. Observed Resident 25's Trelegy inhaler with written open date of 2/3 and stool softener 100 milligram (mg- metric unit of measurement, used for medication dosage and/or amount) with written open date of 2/13. LVN 3 stated Trelegy and stool softener medication did not indicate the year medication was opened. During a medication administration observation on 2/15/2025, at 8:39 a.m., with LVN 3, outside of Resident 58's room. Observed prostat (a ready-to-drink concentrated liquid protein) bottle with written open date of 2/13. During an interview on 2/15/2025, at 8:57 a.m., LVN 3 stated prostat bottle did not indicate the year the medication was opened. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/17/2025, at 1:49 p.m., with the Director of Staff Development (DSD), the DSD stated multidose medications should have a written date including the year it was opened. The DSD stated the importance of writing the complete date was to maintain efficacy of the medication and to prevent medication errors. During an interview on 2/17/2025, at 5:13 p.m., with the Director of Nursing (DON), the DON stated nurses should write in the bottle, the date the medication was opened. The DON stated date includes the year it was opened. The DON stated it is the best practice. The DON stated the importance of writing the date with the year the medication was opened to know when to stop using the medication. The DON stated the facility's policy and procedure on labelling medication includes writing the complete date the medication was opened. During a record review of the facility's policy and procedure (P&P) titled, Labelling of Medication Containers, dated 4/2019 and last reviewed on 1/14/2025, the P&P indicated, All medications maintained in the facility are properly labeled in accordance with current state and federal guidelines and regulations. During a record review of the facility's P&P, titled, Administering Medications, dated 4/2019 and last reviewed on 1/14/2025, the P&P indicated, The expiration or beyond use date on the medication label is checked prior to administering. When opening a multidose container, the date opened is recorded on the container. b. During a record review of Resident 32's Admission Record, the Admission Record indicated the facility admitted Resident 32 on 5/17/2021, with diagnoses that included metabolic encephalopathy (a condition where the brain does not function properly due to an underlying metabolic imbalance), generalized muscle weakness, and unspecified (unconfirmed) low back pain. During a record review of Resident 32's History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 10/16/2024, the H&P indicated Resident 32 did not have the capacity to understand and make decisions. During a record review of Resident 32's Minimum Data Set (MDS - a resident assessment tool), dated 12/15/2024, the MDS indicated Resident 32's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 32 was on opioid (medication used to treat moderate to severe pain). During a record review of Resident 32's Physician Order, dated 10/14/2024, the Physician Order indicated Norco tablet 10-325 mg, give one tablet by mouth every six hours as needed for severe breakthrough (a sudden increase in pain that may occur in patients who already have chronic pain) with a pain level of seven to ten. During a record review of Resident 32 Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 2/16/2025, timed at 7:43 a.m., the MAR indicated LVN 1 administered Norco to Resident 32's pain level of zero. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/17/2025, at 1:49 p.m., with the DSD, the DSD stated Norco should not be given to Resident 32 when pain level is zero. The DSD stated zero means Resident 32 had no pain. During an interview on 2/17/2025, at 5:13 p.m., with the DON, the DON stated LVN 1 should check Resident 32's pain level before administering the pain medication. The DON stated the facility's policy for medication administration was to follow the physician order. During a record review of facility's policy and procedure (P&P) titled, Pain-Clinical Protocol, dated 3/2018 and last reviewed on 1/14/2025, the P&P indicated, The physician will order appropriate non-pharmacologic (treatments or therapies that do not involve the use of medications) and medication interventions to address the individual's pain. Pain medications should be selected based on pertinent treatment guidelines. Generally, and to the extent possible, an analgesics (medication used to treat pain) regimen should utilize the simplest regimen and lowest risk medications before using more problematic or higher risk approaches. During a record review of facility's P&P titled, Administering Medications, dated 4/2019 and last reviewed on 1/14/2025, the P&P indicated, Medications are administered in accordance with prescribers' orders, including any required time frame. c. During a record review of Resident 41's Admission Record, the Admission Record indicated the facility admitted Resident 41 on 1/17/2020, with diagnoses that included paroxysmal atrial fibrillation (a type of irregular heartbeat that occurs intermittently and typically resolves on its own), unspecified anxiety disorder (a group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can significantly interfere with daily life) and other lack of coordination. During a record review of Resident 41's H&P, dated 10/29/2024, the H&P indicated Resident 41 did not have the capacity to understand and make decisions. During a record review of Resident 41's MDS, dated [DATE], the MDS indicated Resident 41's cognitive skills for daily decisions were severely impaired. The MDS indicated Resident 41 was on antianxiety medications (medications used to help reduce anxiety). During a record review of Resident 41's Physician Order, dated 2/12/2025, the Physician Order indicated clonazepam (medication used to treat anxiety) 0.5 mg tablet, give 0.25 mg by mouth every 12 hours for anxiety manifested by repetitive calling out of staff. During a concurrent interview and record review on 2/15/2025, at 12:52 p.m., with the Assistant Director of Nursing (DON), Resident 41's Medication Count Sheet for clonazepam indicated 62 and 60 tablets were circled. The ADON counted the clonazepam medication pack, and the actual number of clonazepam left in the medication pack was 62 tablets. During an interview on 2/15/2025, at 1:11 p.m., with the ADON, the ADON stated it is important to document accurately in the Medication Count Sheet. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/17/2025 at 1:49 p.m., with the DSD, the DSD stated once medication is delivered, the medication in the medication pack is counted and the number is documented in the Medication Count Sheet. The DSD stated if nurse made two different entries, the nurse should cross out one and leave the right number of medications. During an interview on 2/17/2025, at 5:13 p.m., with the DON, the DON stated nurses should document in the Medication Count Sheet the number of medications received. The DON stated if a nurse made an error, they should cross it out and write the initial of their name. The DON stated accurate documentation is important for controlled medication (a substance that is regulated by the government due to its potential for abuse and addiction) and it is the facility's policy to count and document accurately. During a record review of facility's P&P titled, Controlled Substances, dated 4/2019 and last reviewed on 1/14/2025, the P&P indicated, The facility complies with all laws, regulations and other requirement related to handling, storage, disposal and documentation of controlled medications. Controlled substances are reconciled upon receipt, administration, disposition and at the end of each shift. Upon receipt, the nurse receiving the medication and the individual delivering the medication verify the name, dose and quantity of each controlled substances being delivered. An individual resident-controlled substance record is made for each resident who is receiving a controlled substance. The record contains: 1. Name of resident. 2. Name and strength of the medication 3. Quantity received. 4. Number on hand. d. During a record review of Resident 58's Admission Record, the Admission Record indicated the facility admitted Resident 58 on 2/25/2022, with diagnoses that included Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), hypokalemia (a condition where the potassium levels in the blood are lower than normal. Potassium is an essential electrolyte that plays a vital role in muscle function, nerve signaling, and heart health) and essential hypertension (a condition characterized by persistently high blood pressure without an identifiable underlying cause). During a record review of Resident 58's MDS, dated [DATE], the MDS indicated Resident 58's cognitive skills for daily decisions were intact. During a record review of Resident 58's H&P, dated 1/3/2025, the H&P indicated Resident 58 did not have the capacity to understand and make decisions. During a record review of Resident 58's Order Summary Report, dated 2/26/2024, the Order Summary Report indicated potassium chloride (medication used in the management and treatment of hypokalemia) extended release 20 milliequivalent (meq - unit of measurement), give one tablet by mouth one time a day for supplement. Take with food and full glass of water or juice of four ounces. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a medication administration observation on 2/15/2025, at 8:57 a.m. with LVN 3, at Resident 58's bedside. Observed LVN 3 administer potassium tablet to Resident 58 with two ounces of water. During a concurrent observation and interview on 2/15/2025, at 9:06 a.m., with LVN 3, LVN 3 measured two ounces of water and stated the physician order for potassium administration was to give with full glass of water. LVN 3 stated two ounces is not a full glass of water. LVN 3 stated she (LVN 3) should have followed the physician's order. During an interview on 2/17/2025, at 1:49 p.m. with the DSD, the DSD stated LVN 3 should follow the physician's order for potassium administration with full glass of water. During an interview on 2/1/2025, at 5:13 p.m. with the DON, the DON stated full glass of water is four to eight ounces of water. The DON stated taking potassium with full glass of water helps lessen a stomach upset. The DON stated two ounces is not a full glass. The DON stated it is the facility's policy to follow the physician's order. During a record review of facility's P&P titled, Administering Medications, dated 4/2019 and last reviewed on 1/14/2025, the P&P indicated, Medications are administered in a safe and timely manner and as prescribed. Medications are administered in accordance with prescriber's order, including any required time frame. 43988 e. During a review of Resident 2's Admission Record, the Admission Record indicated the facility originally admitted the Resident 2 on 2/8/2021and readmitted in the facility on 12/27/2024, with diagnoses including dementia (a progressive state of decline in mental abilities), contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of muscle on multiple sites, and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had severely impaired cognition (having the ability to think, learn, and remember clearly) and required total assistance with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident received an anticoagulant. During a re view of Resident 2's H&P, dated 12/30/2024, the H&P indicated Resident 22 did not have the capacity to understand and make decisions. During a review of Resident 2's Order Summary Report, the Order Summary Report indicated a physician's order dated 12/27/2024 for heparin sodium (porcine) injection solution 5000 units per milliliter (units/ml - a unit of measurement) **dispense as written ([NAME])** 5000 units hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) two (2) times a day for blood clot prevention. During a review of Resident 2' care plan (CP) on risk for bleeding or bruising related to use of heparin initiated on 1/21/2025 indicated the following interventions to prevent bleeding or bruising: - Administer medication per physician's order. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Observe for signs and symptoms of bleeding such as tarry stools, blood in urine, bruising, petechiae (red or purple spots underneath the skin that occur as a result of tiny bleeding, which do not blanch on pressure. During a concurrent interview and record review on 2/16/2025 at 2:45 p.m., reviewed Resident 2's physician's order, and MAR with Registered Nurse 1 (RN 1). RN 1 stated Resident 2 did not have a physician's order to monitor for bleeding every shift for the use of anticoagulant heparin. RN 1 stated residents should have a physician's order to monitor residents for signs and symptoms of bleeding due to the use of an anticoagulant. RN 1 stated there should have been a physician's order to monitor Resident 2 for signs and symptoms of bleeding as it placed Resident 32 at risk for untoward cardiac events and hospitalization . During a concurrent interview and record review on 2/17/2025 at 4:19 p.m., reviewed Resident 2's physician's order and MAR with the Assistant Director of Nursing (ADON). The ADON stated Resident 2 did not have a physician's order to monitor the resident for signs of symptoms of bleeding and there was no monitoring for bleeding in the MAR. The ADON stated the licensed nurse (LN) should also obtain a physician's order for monitoring for signs and symptoms of bleeding every shift along with the order for anticoagulant per facility protocol. The ADON stated the LN should have obtained an order for monitoring for signs and symptoms of bleeding addressing Resident 2's use of heparin to prevent complications related to not monitoring the symptoms of bleeding which may lead to hospitalization . During a review of the facility's policy and procedure (P&P titled, Anticoagulant - Clinical Protocol, last reviewed 1/14/2025, the P&P indicated: - Assess for any signs and symptoms related to adverse drug reactions due to the medication alone or in combination with other medications. - Assess for evidence of effects related to the subtherapeutic or greater than therapeutic drug level related to that particular drug) for example, a resident with an above therapeutic level of an anticoagulation medication should be assessed for bleeding. - The nurse shall assess and document or report the current anticoagulant therapy, including drug and current dosage. - Long-term subcutaneous administration of heparin in chronically bed-bound individuals is not indicated or of proven benefit for long-term deep vein thrombosis (DVT - a blood clot that forms in the veins located deep within a limb, usually the lower leg or thigh) prophylaxis. - The staff and physician will monitor for possible complications in individuals who are being anticoagulated and will manage related problems. a. If an individual on anticoagulation therapy shows signs of excessive bruising, or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose. During a review of the facility's P&P titled, Standards of Clinical Practice, last reviewed 1/14/2025, the P&P indicated a policy statement that services provided to the residents are performed in accordance with current acceptable standards of clinical practice.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38552 Based on interview and record review, the facility: 1. Failed to act upon the recommendations of the consultant pharmacist for one of five sampled residents (Resident 20) reviewed for Unnecessary Medications, Psychotropic (medications capable of affecting the mind, emotions, and behavior) Medications, and Medication Regimen Review (MRR-a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication) care area by failing to follow-up with Resident 20's physician regarding the consultant pharmacist's MRR recommendation for a thyroid stimulating hormone (TSH- a blood test that measures this hormone) blood draw due to the resident's use of amiodarone (medication used to treat life-threatening heart rhythm problems). This deficient practice had the potential to place Resident 20 at risk for ineffective treatment or adverse effects. 2. Failed to identify and report irregularities in the drug regimen with the attending physician for one of one sampled resident (Resident 2) reviewed for Anticoagulant (commonly called blood thinner, that increase the time it takes for blood to clot) use. This deficient practice had the potential to cause Resident 2 to receive suboptimal (less than the highest standard or quality) care due to unintended complications related to the side effects (unwanted, unpleasant results of a medication) of anticoagulant use such as bleeding or bruising if not administered correctly which may lead to hospitalization or even death. Findings: 1. During a review of Resident 20's Admission Record, the Admission Record indicated the facility originally admitted the resident on 8/22/2023 and readmitted the resident on 1/22/2025 with diagnoses including cardiomyopathy (a disease of the heart muscle that makes it harder for the heart to pump blood to the rest of the body), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and generalized muscle weakness. During a review of Resident 20's Internal Medicine Initial Evaluation, dated 1/24/2025, the Internal Medicine Initial Evaluation indicated the resident has the capacity to understand and make decisions. During a review of Resident 20's Minimum Data Set (MDS-a resident assessment tool), dated 1/26/2025, the MDS indicated the resident had adequate hearing and clear speech, had the ability to make self understood and understand others. The MDS indicated the resident was dependent on staff for shower/bathe self and required substantial/maximal assistance with upper and lower body dressing and putting on/taking off footwear. The MDS indicated the resident was dependent on staff with mobility including sit to lying, lying to sitting on side of bed, sit to stand, and chair/bed-to-chair transfer. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 20's physician's order, dated 5/27/2024, the physician's order indicated amiodarone hydrochloride oral (by mouth) tablet, give 200 milligrams (mg-a unit of measurement) one time a day related to unspecified atrial fibrillation (a. fib.- irregular and often very rapid heart rhythm). Hold (do not administer) if apical (heartbeat felt at the bottom of the heart) pulse less than 60. During a review of Resident 20's MRR dated 12/4/2024, the MRR indicated resident takes amiodarone and to consider doing (checking) TSH. During a concurrent interview and record review on 2/16/2025 at 3:13 p.m. with the MDS Coordinator (MDSC), Resident 20's physician orders and laboratory results from 12/2024 to 2/16/2025 were reviewed. The MDSC stated there was no TSH blood draw ordered from 12/1/2024 to 2/16/2025. The MDSC stated there was also no baseline TSH blood draw done at the time of the resident's original admission. During a concurrent interview and record review on 2/16/2025 at 3:21 p.m., with the MDSC, Resident 20's nursing progress notes from 12/3/2024 to 1/10/2025 were reviewed. The MDSC stated there were no notes that Resident's MRR was relayed to the resident's physician for TSH blood draw. The MDSC stated the MRR should have been relayed to the resident's physician and should been documented if the physician would have the TSH blood draw done or not. During an interview on 2/17/2025 at 6 p.m., with the Director of Nursing (DON), the DON stated when the consultant pharmacist reviews a resident's medication regimen, the pharmacist provides a report to the physician. The DON further stated the licensed nurses (LN) inform the resident's physician via fax or phone call. The DON stated the LNs then receive a telephone order, whether the physician agrees or disagrees with the pharmacist's recommendation. The DON stated the consultant pharmacist would conduct another MRR the next month to review the residents' medications against the active medications. The DON stated the pharmacist is part of the health team and has a perspective of the effects of medications to the residents. The DON stated Resident 20's MRR for TSH blood draw would allow for monitoring the therapeutic levels of amiodarone to determine amiodarone's potency (strength or effectiveness) to the resident. During a review of the facility-provided undated drug guide titled, Amiodarone Generic, the drug guide indicated monitoring parameters include Thyroid Function Tests (TFTs- used for diagnosis and to monitor treatment of common thyroid gland disorders which includes TSH and thyroid hormones T3 and T4 blood tests) at baseline, then periodically. During a review of the facility's policy and procedure (P&P) titled, Medication Regimen Reviews (MRR) last reviewed on 1/14/2025, the P&P indicated the goal of the MRR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication . Within 24 hours of the MRR, the consultant pharmacist provides a written report to the attending physicians for each resident identified as having non-life-threatening medication irregularity. The report contains: a. the resident's name; b. the name of the medication; c. the identified irregularity; and d. the pharmacist's recommendation. An 'irregularity' refers to the use of medications that is inconsistent with accepted pharmaceutical services standards of practice; is not support by medical evidence; and/or impedes or interferes with achieving the intended outcomes of pharmaceutical services. It may also include the use of medication without indication, without adequate monitoring, in excessive doses, and or in the presence of adverse consequences. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	43988 2. During a review of Resident 2's Admission Record, the Admission Record indicated the facility originally admitted Resident 2 on 2/8/2021 and readmitted the resident on 12/27/2024, with diagnoses including dementia (a progressive state of decline in mental abilities), contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of muscle on multiple sites, and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had severely impaired cognition (having the ability to think, learn, and remember clearly) and required total assistance with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident received anticoagulant. During a review of Resident 2's History and Physical (H&P) dated 12/30/2024, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. During a review of Resident 2's Order Summary Report, the Order Summary Report indicated a physician's order dated 12/27/2024 for heparin sodium (porcine) injection solution 5000 units per milliliter (units/ml - a unit of measurement), dispense as written ([NAME])** 5000 units hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) two (2) times a day for blood clot prevention. During a review of Resident 2's heparin label attached to the heparin box, the label indicated Resident 2's name, heparin 5000 unit per ml subcutaneously (the insertion of medications beneath the skin) every 12 hours for deep vein thrombosis prophylaxis (measures taken to prevent the formation of blood clots in the deep veins, typically in the legs). During a concurrent interview and record review on 2/16/2025 at 2:45 p.m., reviewed Resident 2's physician's order, MAR from 12/2024 to 2/2025, interim Medication Regimen Review (iMRR - a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication done upon admission by the dispensing pharmacy) form, and a photograph of the heparin label with Registered Nurse 1. RN 1 stated the physician's order and MAR did not match the heparin label. RN 1 stated the MAR indicated Resident 2 received the heparin 2 times a day. RN 1 stated the medication should have been held and clarified with the physician prior to administration. RN 1 stated the Charge Nurse (CN) should have checked with the pharmacy that the label did not match the physician's order. RN 1 stated the pharmacy will call the facility if there was a discrepancy with the order and will not dispense the medication if not clarified. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/16/2025 at 4:28 p.m., reviewed Resident 2's physician's order, MAR, iMRR, and the photograph of the heparin label with Registered Nurse 2 (RN 2). RN 2 stated Resident 2 was not on hemodialysis and the physician's order and MAR did not match the heparin label. RN 2 stated it was an order entry error when she (RN 2) chose the wrong order in the electronic health record (EHR). RN 2 stated she did not know what [NAME] meant and that the heparin order did not indicate the route of administration. RN 2 stated the iMRR indicated there were no recommendations and she did not receive a call from the pharmacy to clarify the heparin order. RN 2 stated the five (5) rights of medication administration includes the right route. RN 2 stated the medication should have been held and the physician should have been called to clarify the order. During an interview on 2/17/2025 at 2:42 p.m. with Pharmacy Consultant 1 (Pharm 1), discussed Resident 2's physician's order with Pharm 1. Pharm 1 stated Resident 2's heparin order should have been clarified with the physician prior to administration of the medication. Pharm 1 stated MRRs are completed within the first week of each month and provide the report to the Director of Nursing (DON). Pharm 1 stated iMRR for new admissions are completed by the pharmacy dispensing the medications for the residents. Pharm 1 stated he completes the MRRs for all residents in the facility whether they are new admits or not. Pharm 1 stated during the 1/2025 MRR, he did not have any recommendation for Resident 2 including the route of administration for the heparin. Pharm 1 stated he missed that the order was missing the route of administration. During a review of the facility's policy and procedure (P&P) titled, Medication Regimen Reviews, last reviewed on 1/14/2025, the P&P indicated: - The consultant pharmacist reviews the medication regimen of each resident at least monthly. - Medication regimen reviews are done upon admission and at least monthly thereafter, or more frequently if indicated. - The goal of MRR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication. - The MRR involves a thorough review of the resident's medical record to prevent, identify, and report and resolve medication related problems, medication errors, and other irregularities such as incorrect medications, administration time or dosage forms. - An irregularity refers to the use of medication that is inconsistent with accepted pharmaceutical services standards of practice; is not supported by medical evidence; and/or impedes or interferes with achieving the intended outcomes of pharmaceutical services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 42311 Based on interview and record review, the facility failed to ensure informed consent was obtained for one of five sampled residents (Resident 32) when Resident 32's bupropion (medication used to treat depression [a common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest in activities once enjoyed]) dosage was increased. This deficient practice had the potential to place the residents at risk for receiving unnecessary medication. Findings: During a record review of Resident 32's Admission Record, the Admission Record indicated the facility admitted Resident 32 on 5/17/2021, with diagnoses that included metabolic encephalopathy (a condition where the brain does not function properly due to an underlying metabolic imbalance), generalized muscle weakness and depression. During a record review of Resident 32's History and Physical (H&P - a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 10/16/2024, the H&P indicated Resident 32 did not have the capacity to understand and make decisions. During a record review of Resident 32's Minimum Data Set (MDS - a resident assessment tool), dated 12/15/2024, the MDS indicated Resident 32's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 32 was on antidepressant (medications used to treat symptoms of depression). During a record review of Resident 32's Physician Order, dated 12/19/2024, the Physician Order indicated the following order: 1. bupropion hydrochloride extended release, give 150 milligrams (mg - metric unit of measurement, used for medication dosage and/or amount) by mouth one time a day for depression manifested by lack of motivation with activities of daily living. 2. discontinue bupropion hydrochloride extended release, 100 mg by mouth one time a day for depression manifested by lack of motivation with activities of daily living. During a record review of Resident 32's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 12/2024, the MAR indicated from 12/1/2024 to 12/18/2024, Resident 32 received bupropion 100 mg tablet daily and on 12/19/2024, bupropion 150mg daily was started for Resident 32. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 32's Psychoactive Summary Sheet, dated 11/2024, for bupropion, the Psychoactive Summary Sheet indicated Resident 32 had eight behavioral episodes from 7:00 a.m. to 3:00 p. m. During a concurrent interview and record review, on 2/16/2025, at 2:34 p.m. with the Assistant Director of Nursing (ADON), Resident 32's Gradual Dose Reduction and Informed Consent for bupropion was reviewed. The ADON stated on 10/16/2024, Resident 32's bupropion was decreased from 150 mg to 100 mg. The ADON stated on 12/19/2024, Resident 32's bupropion was increased from 100 mg to 150 mg. The ADON stated the facility obtains new informed consent if psychotropic medications are increased. The ADON stated there was no informed consent obtained from Resident 32 for the increase of bupropion on 12/19/2024. The ADON stated the importance of obtaining new informed consent was for resident's rights and without the consent, bupropion 150 mg should have not been administered to Resident 32. During an interview, on 2/17/2025, at 1:49 p.m., with the Director of Staff Development (DSD), the DSD stated informed consent should have been obtained with any newly ordered psychotropic medication and with dose increase. During an interview, on 2/17/2025, at 5:13 p.m., with the Director of Nursing (DON), the DON stated a new informed consent should have been obtained with any increase of psychotropic medications. The DON stated it is residents' rights and without the signed informed consent, bupropion should have not been administered after the physician increase the dose. The DON stated Resident 32 received bupropion even without the signed informed consent. During a record review of facility's policy and procedure (P&P) titled, Verification of Informed Consent for Psychotherapeutic Medications, dated 6/2024 and last reviewed on 1/14/2025, the P&P indicated, The facility will obtain a written informed consent for treatment using psychotherapeutic drugs and consent renewal every six months. Signed written consent will be recorded in the resident's medical record. Before initiating treatment with psychotherapeutic drugs, facility staff must verify that the resident's health record contains written informed consent with the required signatures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42311 Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five percent (% - unit of measurement) when two medication errors out of 26 total opportunities contributed to an overall medication error rate of 7.69 % affecting two of four residents observed for medication administration (Residents 58 and 2) by: 1. Failing to ensure Licensed Vocational Nurse (LVN) 3 administered Resident 58's potassium chloride (medication used in the management and treatment of hypokalemia [low potassium level in the blood]) with a full glass of water as per physician's order. 2. Failing to ensure LVN 6 clarified Resident 2's heparin (an anticoagulant medication used to prevent and treat blood clots) order before medication administration. These deficient practices had the potential to result in residents experiencing medication adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have) and medication error. Findings: a. During a record review of Resident 58's Admission Record, the Admission Record indicated the facility admitted Resident 58 on 2/25/2022, with diagnoses that included Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), hypokalemia and essential hypertension (a condition characterized by persistently high blood pressure without an identifiable underlying cause). During a record review of Resident 58's Minimum Data Set (MDS - a resident assessment tool), dated 12/3/2024, the MDS indicated Resident 58's cognitive skills for daily decisions was intact. During a record review of Resident 58's History and Physical (H&P - a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 1/3/2025, the H&P indicated Resident 58 did not have the capacity to understand and make decisions. During a record review of Resident 58's Order Summary Report, dated 2/26/2024, the Order Summary Report indicated potassium chloride extended release 20 milliequivalent (meq - unit of measurement), give one tablet by mouth one time a day for supplement. Take with food and full glass of water or juice of four ounces. During a medication administration observation, on 2/15/2025, at 8:57 a.m., with LVN 3, at Resident 58's bedside LVN 3 administered a potassium tablet to Resident 58 with two ounces of water. During a concurrent observation and interview, on 2/15/2025, at 9:06 a.m., with LVN 3, LVN 3 measured two ounces of water and stated the physician order for potassium administration was to give with full glass of water. LVN 3 stated two ounces is not full glass of water. LVN 3 stated she should have followed the physician's order. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 2/17/2025, at 1:49 p.m., with the Director of Staff Development (DSD), the DSD stated LVN 3 should follow the physicians order for potassium administration with full glass of water. During an interview, on 2/17/2025, at 5:13 p.m., with the Director of Nursing (DON), the DON stated a full glass of water is four to eight ounces of water. The DON stated taking potassium with a full glass of water helps lessen upsetting the stomach. The DON stated two ounces is not a full glass. The DON stated it is the facility's policy to follow physician's order. During a record review of facility's policy and procedure (P&P) titled, Administering Medications, dated 4/2019 and last reviewed on 1/14/2025, the P&P indicated, Medications are administered in a safe and timely manner and as prescribed. Medications are administered in accordance with prescriber's order, including any required time frame. b. During a record review of Resident 2's Admission Record, the Admission Record indicated the facility admitted Resident 2 on 2/8/2021, with diagnoses that included unspecified (unconfirmed) encephalopathy (a change in your brain function due to injury or disease), complete atrioventricular block (a problem with your heartbeat signal moving from the upper to lower part of your heart causing irregular heartbeat) and unspecified dementia (a progressive state of decline in mental abilities). During a record review of Resident 2's H&P, dated 12/30/2024, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. During a record review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 2 was on anticoagulant (medication used to prevent blood clot). During a record review of Resident 2's Physician Order, dated 12/27/2024, the Physician Order indicated heparin sodium injection (the act of putting a liquid, especially a drug, into a person's body using a needle and a syringe) solution 5,000 unit per milliliter (ml - unit of measurement), dispense as written ([NAME] - means that a doctor is instructing a pharmacist to provide the exact medication prescribed, without substituting a generic version, even if a cheaper alternative is available) 5000-unit hemodialysis (a medical procedure that filters waste products and excess fluid from the blood when the kidneys are no longer functioning properly) two times a day for blood clot prevention. During a record review of Resident 2's heparin label attached to the heparin box, the label indicated Resident 2's name, heparin 5000 unit per ml subcutaneously (the insertion of medications beneath the skin) every 12 hours for deep vein thrombosis prophylaxis (measures taken to prevent the formation of blood clots in the deep veins, typically in the legs). During a concurrent observation and interview, on 2/16/2025, at 5:12 p.m., with LVN 6, outside of Resident 2's room LVN 6 read and compared the physician order for heparin, dated 12/27/2024, to the label attached to the heparin box. LVN 6 administered heparin to Resident 2's right lower quadrant of the abdomen. LVN 6 stated the physician order did not match the heparin label. LVN 6 stated the physician's order should match the medication label. LVN 6 stated she should have notified Registered Nurse (RN) 2 before heparin administration. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on 2/17/2025, at 8:09 a.m., with the Assistant Director of Nursing (ADON), Resident 2's Physician Order, dated 12/27/2024, was reviewed. The ADON stated [NAME] in Resident 2's Physician Order for heparin means dispense as written. The DON stated the Physician Order did not indicate a route of administration. The ADON stated Resident 2 was not on hemodialysis. The ADON stated LVNs who administered the medication should have clarified the order first with the physician. The ADON stated LVNs should follow the physician order than the medication label. The ADON stated LVN 6 made a significant medication error. The ADON stated the five rights of medication administration includes the right route. The ADON stated the route was not followed as it was not indicated in the physician order. During an interview, on 2/17/2025, at 1:49 p.m., with the DSD, the DSD stated LVN 6 should clarify the heparin order before medication administration. During an interview, on 2/17/2025, at 5:13 p.m., with the DON, the DON stated nurses should follow the procedure of medication administration that includes the right resident, right medication, right order and reconcile on what's on the medication label. The DON stated LVN 6 should have called the physician and clarify the route. The DON stated Resident 2 can have an adverse effect from the medication. During a record review of facility's P&P titled, Administering Medications, dated 4/2019 and last reviewed on 1/14/2025, the P&P indicated, Medications are administered in a safe, timely manner and as prescribed. Medications are administered in accordance with prescribers' orders, including any required time frame. If a dosage if believed to be inappropriate or excessive for a resident, or a medication had been identified as having potential adverse consequences for the residents or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the residents attending physician or the facility's medical director to discuss the concerns. The individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on interview and record review, the facility failed to ensure residents were free of any significant medication errors (means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order, manufacturer's specifications, and accepted professional standards): 1. For one of one sampled resident (Resident 32) reviewed for insulin (a hormone that lowers the level of glucose [a type of sugar] in the blood) by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (beneath the skin) the insulin administration sites. This deficient practice had the potential for adverse effect (unwanted, unintended result) of same site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). 2. For one of one sampled resident (Resident 2) reviewed for anticoagulant (commonly called blood thinner, that increase the time it takes for blood to clot) use by: a. Failing to clarify that Resident 2's physician's order for heparin (an anticoagulant) did not indicate the route of administration and the correct indication. b. Failing clarify the pharmacy label on the heparin did not match the physician's order and Medication Administration Record (MAR - a daily documentation record used by a LN to document medications and treatments given to a resident) prior to administration of the medication. These deficient practices had the potential to cause Resident 2 to receive suboptimal (less than the highest standard or quality) care due to unintended complications related to the side effects (unwanted, unpleasant results of a medication) of anticoagulant use such as bleeding or bruising if not administered correctly which may lead to hospitalization or even death. Findings: a. During a review of Resident 32's Admission Record, the Admission Record indicated the facility originally admitted the resident on 1/24/2025 with diagnoses including type two (2) diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing), dementia (a progressive state of decline in mental abilities), and generalized muscle weakness. During a review of Resident 32's History and Physical (H&P) dated 10/16/2024, the H&P indicated Resident 32 did not have the capacity to understand and make decisions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 32's Minimum Data Set (MDS, a resident assessment tool), tool), dated 12/15/2025, the MDS indicated Resident 32 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required supervision or touching assistance with eating; total assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS further indicated Resident 32 received insulin. During a review of Resident 32's Order Summary Report, the Order Summary Report indicated the following physician's orders dated: - 2/12/2024: Lantus solution (a long-acting insulin [a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication])100 unit per milliliter (unit/ml - a unit of measurement) inject 34 units subcutaneously (beneath the skin) at bedtime related to DM 2. Hold if blood sugar (BS) is less than (<) 100. - 1/7/2025: Lantus solution 100 unit/ml (insulin glargine) inject 26 units subcutaneously at bedtime related to DM 2. Hold if BS <100. - 12/8/2024: Lantus solution 100 unit/ml (insulin glargine) inject 26 units subcutaneously at bedtime related to DM 2. - 10/14/2024 to 1/24/2025: Novolog solution (a short acting insulin)100 unit/ml (insulin aspart) inject as per sliding scale (increasing administration of the pre?meal insulin dose based on the blood sugar level before the meal): <60, hypoglycemic protocol and inform physician (MD); if 60 - 149 = 0 unit;150 - 199 = 2 units; 200 - 249 = 4 units; 250 - 299 = 6 units; 300 - 349 = 8 units; 350 - 399 = 10 units; 400 plus = 12 unit; more than (>) 400, 12 units and inform MD subcutaneously before meals and at bedtime for DM 2. - 1/24/2025: Novolog solution 100 unit/ml (insulin aspart) inject as per sliding scale: <60, hypoglycemic protocol and inform physician (MD); if 60 - 149 = 0 unit;150 - 199 = 2 units; 200 - 249 = 4 units; 250 - 299 = 6 units; 300 - 349 = 8 units; 350 - 399 = 10 units; 400 plus = 12 unit; > 400, 12 units and inform MD subcutaneously with meals for DM 2. During a concurrent interview and record review on 2/16/2025 at 2:22 p.m., reviewed Resident 32's physician's orders, MAR Location of Administration Report for 1/2025 and 2/2025 with Licensed Vocational Nurse 1 (LVN 1). LVN 1 stated Resident 32 had a physician's order for Novolog and Lantus and were administered as follows: - Lantus solution 100 unit/ml: 1/13/25 10:45 p.m. subcutaneously Abdomen - left upper quadrant (LUQ) 1/14/25 9:14 p.m. subcutaneously Abdomen - LUQ 2/12/25 9:40 p.m. subcutaneously Abdomen - right upper quadrant (RUQ) 2/13/25 9:11 p.m. subcutaneously Abdomen - RUQ (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Novolog solution 100 unit/ml: 1/02/25 9:00 p.m. subcutaneously Abdomen - left lower quadrant (LLQ) 1/03/25 5:45 a.m. subcutaneously Abdomen - LLQ 1/15/25 8:55 p.m. subcutaneously Abdomen - LUQ 1/16/25 6:27 a.m. subcutaneously Abdomen - LUQ 1/16/25 11:53 a.m. subcutaneously Abdomen - RUQ 2/03/25 8:55 p.m. subcutaneously Abdomen - RUQ 2/04/25 9:01 p.m. subcutaneously Abdomen - RUQ 2/11/25 9:02 p.m. subcutaneously Abdomen - LUQ 2/12/25 9:40 p.m. subcutaneously Abdomen - LUQ 2/13/25 9:13 p.m. subcutaneously Abdomen - LUQ 2/14/25 8:29 p.m. subcutaneously Abdomen - LUQ 2/07/25 4:21 p.m. subcutaneously Abdomen - right lower quadrant (RLQ) 2/08/25 8:42 a.m. subcutaneously Abdomen - RLQ 2/08/25 1:15 p.m. subcutaneously Abdomen - RLQ 2/15/25 7:47 a.m. subcutaneously Abdomen - LUQ 2/15/25 12:10 p.m. subcutaneously Abdomen - LUQ 2/16/25 7:39 a.m. subcutaneously Abdomen - LUQ 2/16/25 11:26 a.m. subcutaneously Abdomen - LUQ LVN 1 stated insulin administration sites should be rotated per standards of practice, manufacturer's guidelines, and according to physician's orders. LVN 1 stated the last three (3) administration sites for insulin was shown every time the staff opens the MAR. LVN 1 stated Resident 32's MAR indicated the insulin administration sites were not rotated. LVN 1 stated Resident 32's insulin administration sites should have been rotated per standards of practice to prevent pain, redness, irritation, bruising, and pits on the resident's skin. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 2/17/2025 at 4:30 p.m., reviewed Resident 32's physician's orders, MAR Location of Administration Report for 1/2025 and 2/2025 with the Assistant Director of Nursing (ADON). The ADON stated the locations of administration sites for Resident 32's insulin were not rotated. The ADON stated the charge nurses (CN) are supposed to rotate insulin administration sites according to standards of practice and as indicated in the manufacturer's guideline and the CN can see the last 3 administration sites of insulin in the MAR. The ADON stated Resident 32's administration sites for insulin should have been rotated to prevent adverse effects such as bruising, skin irritation, skin pits, lipodystrophy and amyloidosis which can affect absorption of the insulin. The ADON not rotating the insulin administration sites can be considered a medication error due to the CN not following professional standards of practice and manufacturer's guideline or recommendation. During a review of the facility-provided manufacturer's guideline on Lantus insulin glargine injection 100 unit/ml, undated, the manufacturer's guideline indicated: - Change (rotate) the injection sites within the area chosen with each dose to reduce the risk of getting lipodystrophy (pitted or thickened skin) and localized cutaneous amyloidosis 9skin with lumps) at the injection sites. - Do not use the same spot for each injection or inject where the skin is pitted, thickened, lumpy, tender, bruised, scaly, hard, or damaged. During a review of the facility-provided manufacturer's guideline on Insulin aspart (vials) (Novolog), undated, the manufacturer's guideline indicated: - Move site where you give the shot each time. - It is given as a shot into the fatty part of the skin in the upper arm, buttocks, or stomach area. - A side effect include thick skin pits, or lumps where the injection was given. - Do not give into skin that is thickened, or has pits, or has lumps. - Do not into skin that is irritated, tender, bruised, red, scaly, hard, scarred. During a review of the facility policy and procedures (P&P) titled, Insulin administration, last reviewed on 1/14/2025, the P&P indicated: - Select an injection site: a. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately two (2) inches above the navel. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P, titled, Adverse Consequences and Med Errors, last reviewed on 1/14/2025, the P&P indicated: - A medication error is defined as preparation or administration of drugs or biologicals which is not in accordance with physician's orders, manufacturer's specifications or accepted professional standards and principles of the professionals providing the services. b. During a review of Resident 2's Admission Record, the Admission Record indicated the facility originally admitted Resident 2 on 2/8/2021 and readmitted the resident on 12/27/2024, with diagnoses including dementia (a progressive state of decline in mental abilities), contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of muscle on multiple sites, and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had severely impaired cognition (having the ability to think, learn, and remember clearly) and required total assistance with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident received anticoagulant. During a re view of Resident 2's History and Physical (H&P) dated 12/30/2024, the H&P indicated Resident 22 did not have the capacity to understand and make decisions. During a review of Resident 2's Order Summary Report, the Order Summary Report indicated a physician's order dated 12/27/2024 for heparin sodium (porcine) injection solution 5000 units per milliliter (units/ml - a unit of measurement) **dispense as written ([NAME])** 5000 units hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) two (2) times a day for blood clot prevention. During a concurrent observation, interview and record review on 2/16/2025 at 2:42 p.m., reviewed Resident 2's physician's order and MAR for 2/2025 with LVN 1. LVN 1 stated Resident 2 was not on dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney/s have failed). LVN 1 stated Resident 2's physician's order for heparin dated 12/27/2024 and the MAR did not indicate the route of administration. Medication Cart 2 (MC 2) was checked with LVN 1 and LVN 1 stated the label on the heparin indicated the administration route was to administer the medication subcutaneously for deep vein thrombosis (DVT - a blood clot that forms in the veins located deep within a limb, usually the lower leg or thigh) prophylaxis (refers to measures taken to prevent diseases or infections before they occur). LVN 1 stated the physician's order, MAR, and medication label did not match. LVN 1 stated the nurses are supposed to compare the medication label with the MAR, and if there was discrepancy then the order must be checked, hold (do not administer) the medication and clarify the order with the physician. LVN 1 stated Resident 2 received the heparin since 12/28/2024. LVN 1 stated Resident 2's heparin should have been held and clarified with the physician prior to administering the medication. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 2/16/2025 at 2:45 p.m., reviewed Resident 2's physician's order, MAR from 12/2024 to 2/2025, interim Medication Regimen Review (iMRR - a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication done upon admission by the dispensing pharmacy) form, and a photograph of the heparin label with Registered Nurse 1. RN 1 stated the physician's order and MAR did not match the heparin label. RN 1 stated the physician's order and MAR indicated the route of administration. RN1 stated the MAR indicated Resident 2 received the heparin two times a day. RN 1 stated the medication should have been held and clarified with the physician prior to administration. RN 1 stated the CN should have checked with the pharmacy that the label did not match the physician's order. RN 1 stated the pharmacy will call the facility if there was a discrepancy with the order and will not dispense the medication if not clarified. During a concurrent observation, interview, and record review on 2/16/2025 at 4:07 p.m., reviewed Resident 2's physician's order, MAR, and heparin label with Licensed Vocational Nurse 6 (LVN 6). LVN 6 stated the physician's order and MAR did not indicate the route of administration. LVN 6 stated the physician's order should match the medication label. LVN 6 stated the CN should have held the medication and notify the RN supervisor of clarify the order with the physician. During a concurrent interview and record review on 2/16/2025 at 4:28 p.m., reviewed Resident 2's physician's order, MAR, iMRR, and the photograph of the heparin label with Registered Nurse 2 (RN 2). RN 2 stated Resident 2 was not on hemodialysis and the physician's order and MAR did not match the heparin label. RN 2 stated it was an order entry error when she (RN 2) chose the wrong order in the electronic health record (EHR). RN 2 stated she did not know what [NAME] meant and the heparin order did not indicate the route of administration. RN 2 stated the iMRR indicated there were no recommendations and she did not receive a call from the pharmacy to clarify the heparin order. RN 2 stated the five (5) rights of medication administration includes the right route. RN 2 stated the medication should have been held and call the physician to clarify the order. During a concurrent interview and record review on 2/17/2025 at 8:09 a.m., with the Assistant Director of Nursing (ADON), Resident 2's Physician Order dated 12/27/2024 was reviewed. The ADON stated [NAME] in Resident 2's Physician Order for heparin means dispense as written. The DON stated the Physician Order did not indicate route of administration. The ADON stated Resident 2 was not on hemodialysis. The ADON stated CN who administered the medication should have clarify the order first with the physician. The ADON stated CN should follow the physician order instead of the medication label. The ADON stated LVN 6 made a significant medication error. The ADON stated the five rights of medication administration includes the right route. The ADON stated route was not followed as it was not indicated in the physician order. During a follow up concurrent interview and record review on 2/17/2025 at 4:19 p.m. reviewed Resident 2's MAR from 1/2024 to 2/2025 with the ADON, the ADON stated the heparin was administered two times a day for a total of 102 instances. The ADON stated administering the heparin without the route of administration was considered a medication error as the route was not indicated in the physician's order. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/17/2025 at 5:13 p.m., with the DON, the DON stated nurses should follow the procedure of medication administration that includes the right resident, right medication, right order, right route, and right indication, and reconcile on what's on the medication label. The DON stated the CNs should have held the medication and called the physician and clarify the route of administration. The DON stated Resident 2 can have an adverse effect from receiving the medication without the route of administration. The DON stated administering the heparin to Resident 2 without the route of administration from 12/28/2024 to 2/16/2025 for a total of 102 instances was considered a significant medication error. During a record review of facility's policy and procedure (P&P) titled, Administering Medications last reviewed on 1/14/2025, the P&P indicated: - Medications are administered in a safe, timely manner and as prescribed. - Medications are administered in accordance with prescribers' orders, including any required time frame. - If a dosage if believed to be inappropriate or excessive for a resident, or a medication had been identified as having potential adverse consequences for the residents or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the residents attending physician or the facility's medical director to discuss the concerns. - The individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. During a review of the facility's P&P titled, Adverse Consequences and Med Errors, last reviewed on 1/14/2025, the P&P indicated: - A medication error is defined as preparation or administration of drugs or biologicals which is not in accordance with physician's orders, manufacturer's specifications or accepted professional standards and principles of the professionals providing services. - Example of medication error include wrong route of administration. - An adverse consequence is defined as an unpleasant symptom or event that is due to or associated with a medication, such as impairment or decline in an individual's mental or physical condition or functional or psychosocial status. An adverse consequence may include adverse drug/medication reaction and side effect. - An adverse drug reaction is any unintended response to a drug and occurs in doses for prophylaxis, diagnosis or therapy. - When a resident receives a new medication, the medication order is evaluated for the dose, route of administration, duration, and monitoring that are in agreement with current clinical practice, clinical guidelines, and/or manufacturer's specifications for use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43878 Based on observation, interview, and record review, the facility failed to follow the menu and did not meet nutritional needs of one of three sampled residents (Resident 38) reviewed under the kitchen care area. This deficient practice had the potential to result in decreased food and nutrient intake which may result in unintended (not planned) weight loss. Findings: During a review of Resident 38's Admission Record, the Admission Record indicated Resident 38 was admitted on [DATE] with diagnoses including muscle weakness (generalized), adult failure to thrive (decline in health that can occur in older people), and essential (primary) hypertension (HTN- high blood pressure). During a review of Resident 38 Care Plan dated 10/5/2024, the Care Plan indicated the resident is at nutritional risk secondary to failure to thrive. Interventions included diet as ordered, provide and honor food preferences. During a review of Resident 38's Order Summary dated 10/10/2024, the Order Summary indicated a physician's order for no added salt diet, regular texture, and regular liquid consistency. During a review of Resident 38's Minimum Data Set (MDS - a resident assessment tool) dated 1/7/2025, the MDS indicated the resident had the ability to understand and be understood. During a review of the facility's menu titled, Good for your Health Menus, for 2/10/2025 to 2/16/2025, the menu indicated the dinner menu for 2/15/2025 was: - Baked ziti - [NAME] beans with onions and red peppers - Garlic bread - Butterscotch pears During a concurrent observation of the tray line and interview with the Dietary Supervisor (DS) on 2/15/2025 at 4:37 p.m., the DS stated they substituted spinach for the green beans because there was an issue with the delivery of the green beans. During a concurrent observation and interview on 2/15/2025 at 6:51 p.m. with Resident 38, observed Resident 38 sitting up on bed with the food tray in front of her. Resident 38 stated corn was served instead of green beans that was on the menu. Resident 38 stated she does not like corn and refuses to eat the corn. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/16/2025 at 2:18 p.m. with the DS, the DS stated she is the one in charge of ordering food. The DS stated the dinner menu on 2/15/2025 needed to be green beans but a wrong item (spinach) was sent. The DS stated when the menu is changed, they need to make a substitute for a vegetable to vegetable and to be approved by the Registered Dietitian (RD). The DS stated they ran out of spinach and so they substituted it with corn. The DS stated she was not aware that Resident 38 did not want to eat the corn. The DS stated residents may get upset and frustrated because they did not get green beans. The DS stated residents should have offered food substitute as they might be disappointed with the menu pairing. During an interview on 2/16/2025 at 2:26 p.m. with the RD, the RD stated she was aware corn was substituted for spinach. The RD stated she approved the substitution. The RD stated since Resident 38 did not eat the corn, the resident's intake can be affected. During a review of the facility's policies and procedures (P&P) titled Menus, dated 1/14/2025, the P&P indicated menus shall meet the nutritional needs of resident, be prepared in advance and be followed. Deviation from menus that have already been posted will be noted in the kitchen and/or in the record book used solely for recording such changes. During a review of the facility's policies and procedures (P&P) titled Substitutions, dated 1/22/2025, the P&P indicated, residents' likes and dislikes will be considered when making substitutions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43878 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: 1. Temperatures were not checked on ,d+[DATE], ,d+[DATE] and ,d+[DATE] for the dry storage room. 2. The following food items were not discarded: - Corn flakes with use by date of [DATE] - Breadcrumbs with use by date of [DATE] - Beans with use by date of [DATE] - [NAME] cheese with use by date of [DATE] 3. Food items were not properly labeled with either missing received date, open date and/or use by date for: - Lentils - Lays chips - Soy sauce These deficient practices had the potential to result in harmful bacterial growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in medically compromised residents who received food from the kitchen. Findings: During an initial observation tour of the kitchen on [DATE] at 7:06 a.m. in the dry storage room, observed Storage Room Temperature Log, for the month of February 2025 indicating no temperatures for: - [DATE] p.m. - [DATE] a.m. and p.m. - [DATE] a.m. During an initial observation tour of the kitchen on [DATE] at 7:16 a.m., in the dry storage room, observed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Corn flakes with use by date of [DATE] - Breadcrumbs with use by date of [DATE] - Beans with use by date of [DATE] - Lentils in clear container with no received date, open date, or use by date - Lays chips with a date of [DATE] - Soy sauce with no received date, open date and/or use by date. During an initial observation tour of the kitchen on [DATE] at 7:29 a.m. of the kitchen refrigerator, observed Monterey cheese labeled with date of [DATE] and use by date of [DATE]. During a concurrent observation of the kitchen and interview with [NAME] 1 (C 1), on [DATE] at 8:09 a.m., C 1 stated all foods should be labeled with received date, open date, and use by date. C 1 stated food items need to be properly labeled to ensure items are not expired. C 1 reviewed the Monterey cheese and stated based on use by date, the cheese is expired, it should not be in the refrigerator, and it needs to be discarded. C 1 stated having expired food items in the refrigerator can be a risk for residents to consume and the residents to get sick. During an interview on [DATE] at 1:57 p.m. with the Dietary Supervisor (DS), the DS stated the cooks sign off (check and record) the temperatures of the dry storage room two times a day. The DS stated it is important to track the temperatures to keep the temperatures within range for food safety. The DS stated if food is not safe, bacteria can grow rapidly, and residents can get sick if they consume food. During an interview on [DATE] at 2:01 p.m. with the DS, the DS stated all foods should be labeled with received date, open date, and use by date. The DS stated labeling should be done to ensure they have a used by date for residents to consume safely. The DS stated the Monterey cheese should be discarded as they were unable to tell when it is expired but based on the use by date, the cheese should have been discarded. During a review of the facility's policy and procedures (P&P) titled, Labeling and Dating of Foods, last reviewed on [DATE], the P&P indicated all food items in the storeroom, refrigerator, and freezer need to be labeled and dated. Food delivered to facility needs to be marked with a received date. Newly opened food items will need to be closed and labeled with an open date and use by the date follows the various storage guideline. During a review of the facility's P&P titled, Corrective action when food in the storeroom reaches above 85 Fahrenheit (F), last reviewed on [DATE], the P&P indicated when temperature within the emergency or food storage room becomes higher than 85 F, corrective action must take place to ensure food has not become compromised. 2. The Dry Food Storage Temperature Log will be started to monitor storage unit temperature

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 42311 Based on interview and record review the facility failed to maintain accurate and complete medical records for one of four sampled residents (Resident 20). This deficient practice had the potential to cause confusion in care and the medical records containing inaccurate documentation. Findings: During a record review of Resident 20's Admission Record, the Admission Record indicated the facility admitted Resident 20 on 8/22/2023, with diagnoses that included metabolic encephalopathy (change in how your brain works due to an underlying condition), diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing) and unspecified (unconfirmed) cardiomyopathy (a group of heart muscle diseases that weaken the heart's ability to pump blood effectively throughout the body). During a record review of Resident 20's History and Physical (H&P - a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 1/24/2025, the H&P indicated Resident 20 had the capacity to understand and make decisions. During a record review of Resident 20's Minimum Data Set (MDS - a resident assessment too), dated 11/20/2024, the MDS indicated Resident 20's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. During a record review of Resident 20's Physician Order, dated 1/22/2025, the Physician Order indicated Sacubitril-Valsartan (a combination of two medication used to treat chronic heart failure [a condition where the heart muscle is weakened and cannot pump blood effectively]) oral tablet 24-26 milligram (mg - metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth two times a day for dilated cardiomyopathy (a type of heart muscle disease that causes the heart chambers to thin and stretch, growing larger). Hold for systolic blood pressure (sbp - pressure in the arteries when the heart beats) less than 110. During a record review of Resident 20's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 1/2025, the MAR indicated, on 1/3/2025, at 5:00 p.m., Licensed Vocational Nurse (LVN) 2 administered Sacubitril-Valsartan with a documented blood pressure of 18/62. During a concurrent interview and record review, on 2/15/2025, at 2:43 p.m., with LVN 2, Resident 20's MAR, dated 1/2025, was reviewed. LVN 2 stated he meant to document 118/62 and not 18/62. LVN 2 stated it was inaccurate documentation. During an interview, on 2/17/2025, at 1:49 p.m., with the Director of Staff development (DSD), the DSD stated LVN 2 should have rechecked the blood pressure if it was low and document correctly. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 2/17/2025, at 5:13 p.m., with the Director of Nursing (DON), the DON stated LVN 2 should have corrected his documentation. The DON stated the importance of accurate documentation was to make sure treatment and medication is given according to what the physician order. The DON stated if documented blood pressure was 18/62, medication should have been held. During a record review of facility's policy and procedure titled, Charting and Documentation, dated 7/2017 and last reviewed on 1/14/2025, the P&P indicated, Documentation in the medical record will be objective (not opinionated or speculative), complete and accurate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on interview and record review, the facility failed to ensure necessary care was provided consistently for one of one sampled resident (Resident 39) reviewed for hospice services (a program designed to provide a caring environment for meeting the physical and emotional needs of the terminally ill) by failing to ensure there was documented evidence that the resident and/or resident representative was involved during the initial interdisciplinary team (IDT - a team of healthcare professionals from different professional disciplines who work together to manage the physical, psychological, and spiritual needs of the patient) meeting for admission to discuss the hospice plan of care. This deficient practice had the potential to negatively affect Resident 39's physical comfort and psychosocial well-being resulting in the delay or lack of necessary hospice care and services. Findings: During a review of Resident 39's Admission Record, the Admission Record indicated Resident 39 was originally admitted to the facility on [DATE] and readmitted the resident on 4/27/2024 with diagnoses including Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), dementia (a progressive state of decline in mental abilities), and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 39's History and Physical (H&P) dated 4/28/2024, the H&P indicated Resident 39 did not have the capacity to understand and make decisions. During a review of Resident 39's Minimum Data Set (MDS, a resident assessment tool), dated 1/30/2025, the MDS indicated Resident 39 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required substantial/maximal assistance with eating and bed mobility; total assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 39 received hospice services. During a review of Resident 39's Order Summary Report, the Order Summary Report indicated a physician's order dated 1/21/2025 to admit Resident 39 to Hospice Provider 1 (HP 1) under routine level of care with a diagnosis of Parkinson's disease. During a review of Resident 39's Current Treatment/Medication/Durable Medical Equipment (DME) list form provided by HP 1 to the facility dated 1/23/2025, the Current/Medication/DME list form indicated IDT to review patient's status every 14 days and as needed to evaluate changes in condition. During a review of Resident 39's IDT Progress Note form dated 1/20/2025, the IDT Progress Note indicated the participants were the Social Services Director (SSD), Director of Rehabilitation (DOR) Department, and the Case Manager (CM). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/17 2025 at 8:27 a.m., reviewed Resident 39's IDT Progress Note dated 1/20/2025 with the SSD. The SSD stated the IDT Progress Note indicated only facility staff was present during the IDT addressing hospice care and services to be provided to the resident. The SSD stated IDT meetings are conducted with the resident and/or resident representative on admission, quarterly, and with as needed with any changes in condition either in person or thru the telephone. The SSD stated Resident 39's IDT Progress Note did not indicate Resident 39 and/or resident representative were present in any portion of the IDT meeting. The SSD stated the progress note should have indicated Resident 39 and/or the family was present during the IDT meeting to ensure Resident 39 and/or the family are aware of and involved in the development of Resident 39's plan of care and prevent potential delay in providing the hospice services. During a concurrent interview and record review on 2/17/2025 at 11:23 a.m., reviewed Resident 39's IDT Progress Note dated 1/20/2025 with the Assistant Director of Nursing (ADON). The ADON stated the IDT Progress Note did not indicate that Resident 39 and/or his representative were present in any portion of the IDT meeting. The ADON stated Resident 39 and/or his representative should have been present thru the phone or in person to ensure that they were aware of and involved in the plan of care and the hospice services Resident 39 will receive. The ADON stated if Resident 39 and/or the representative was not involved in the development of the plan of care there could be potential delay in providing the necessary hospice care and services Resident 39 needed. During a review of the facility's policy and procedure (P&P) titled, Hospice Program, last reviewed on 1/14/2025, the P&P indicated: - Coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the car and services provided by the facility to maintain the resident's highest practicable physical, mental, and psychosocial well-being. - The coordinated care plan will reflect the resident's goals, and wishes, and during ongoing communication with the resident or representative, including goals and objectives, interventions, and medical treatment and diagnostic tests. During a review of the facility's P&P titled Care Planning - Interdisciplinary Team, last reviewed on 1/14/2025, the P&P indicated: - The facility's care planning/IDT is responsible for the development of an individualized comprehensive care plan for each resident. - The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. - The mechanics of how the IDT meets its responsibilities in the development of the interdisciplinary care plan, such as face-to-face, teleconference, written communication, etc., is at the discretion of the care planning committee.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 42311 Based on interview and record review, the facility failed to implement infection control measures by failing to ensure: 1. Prostat (supplement for dietary management of wounds and other conditions requiring increased protein) bottle was kept in a clean and in sanitary condition before and after use for two of four sampled medication carts (Medication Carts 1 and 4). 2. The Maintenance Director (MS) and the Infection Preventionist (IP) were able to identify signs of legionella (a severe form of pneumonia - lung inflammation usually caused by infection) as indicated in the legionella water management program. These deficient practices had the potential to result in unidentified cases of legionella and the spread of infection in the facility as well as prostat bottle contamination (the process of making something dirty). Findings: 1. During a concurrent medication administration observation and interview, on 2/15/2025, at 9:11 a.m., with Licensed Vocational Nurse (LVN) 5, outside of Resident 12's room LVN 5 pulled a Prostat bottle from the bottom fourth (4th) drawer of Medication Cart number 1. The Prostat bottle had light brown drippings on the side of the bottle. LVN 5 poured 30 milliliter (ml - unit of measurement) of Prostat in a medication cup and closed the cover. LVN 5 held the Prostat bottle and stated the Prostat bottle was sticky. LVN 5 returned the Prostat bottle in the bottom cart of the medication cart without cleaning the bottle. During a concurrent observation and interview, on 2/16/2025, at 9:15 a.m., with LVN 3, LVN 3 pulled a Prostat bottle from the bottom 4th drawer of Medication Cart Number 1. The Prostat bottle had dried light brown drippings on the side. LVN 3 stated the Prostat bottle is a little sticky to touch. LVN 3 stated nurses should have cleaned the bottle after every use to prevent cross contamination. During a concurrent observation and interview, on 2/16/2025, at 9:21 a.m., with LVN 4, LVN 4 pulled a Prostat bottle from the bottom 4th drawer of Medication Cart Number 4. The Prostat bottle had dried light brown drippings on the side. LVN 4 stated the Prostat bottle was dirty and sticky. LVN 4 stated she did not clean the Prostat bottle this morning. LVN 4 stated the importance of cleaning the Prostat bottle was for infection control. During an interview, on 2/17/2025, at 1:49 p.m., with the Director of Staff Development (DSD), the DSD stated if a medication bottle is sticky, staff should wipe it off and clean it. During an interview, on 2/17/2025, at 5:13 p.m., with the Director of Nursing (DON), the DON stated staff needs to check their supplies in their medication carts and clean it before and after medication administration for infection control. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of facility's policy and procedure (P&P) titled, Surveillance of Infections, dated 9/2023, and last reviewed on 1/14/2025, the P&P indicated, Ensures that reusable equipment is appropriate cleaned or disinfected after each use and only single-use vials are used. Staff follows established facility infection control procedures (handwashing, antiseptic technique [a set of practices that help prevent the spread of infection], gloves, isolation precautions [steps taken to prevent the spread of germs in hospitals and other settings]) for the administration of medication, as applicable. 2. During a concurrent interview and record review on 2/15/2025 at 2:55 p.m., with the Maintenance Director (MS), the facility's policy and procedure (P&P) titled, Legionella Water management Program dated 9/2022 was reviewed. The P&P indicated, the identification of situations that can lead to legionella growth, such as . 4.the presence of biofilm, scale or sediment. The MS stated he (MS) checks the facility for stagnant (not flowing) water and randomly (chosen by chance rather than according to a plan) selects water sample to be send out for legionella testing once a year. The MS stated he (MS) did not know the signs of legionella in the water. The MS stated he did not know what biofilm was. The MS stated it is important to know what biofilm was so if he (MS) sees any presence of biofilm in the water in the facility, he (MS) can collect the sample and send out for legionella testing without waiting for another year. During a concurrent interview and record review on 2/15/2025 at 3:16 p.m. with the IP, the facility's Lesson Plan for Legionella Water Management Program dated 2/3/2025 was reviewed. The Lesson Plan indicated, The identification of situations that can lead to legionella growth, such as .4.the presence of biofilm, scale or sediment. The IP stated the MS was in-charge of checking the facility for stagnant water. The IP stated she (IP) provided the in-service (education) for the legionella to the MS. The IP stated she did not know what biofilm was. During an interview on 2/17/2025 at 1:49 p.m., with the DSD, the DSD stated the MS assigned to inspect the facility should know possible signs of legionella in the stagnant water. During an interview on 2/17/2025 at 3:10 p.m. with the Administrator (ADM), the ADM stated the MS should know what to look for possible signs of legionella in the water. The ADM stated the MS was the one that randomly selects the sample of water to be tested for legionella. The ADM stated the importance of identifying signs of legionella in the water was to prevent any cases and spread among residents. During a record review of facility P&P titled, Legionella Water Management Program dated 9/2022 and last reviewed on 1/14/2025, the P&P indicated, Our facility is committed to the prevention, detection and control of water -borne contaminants, including legionella. As part of the infection prevention and control program. Our facility has a water management program, which is overseen by the water management team. The purpose of the water management program is to identify areas in the water system where legionella bacteria can grow and spread and to reduce the risk of Legionnaires Disease The identification of situations that can lead to legionella growth, such as .4.the presence of biofilm, scale or sediment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 42311 Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 20) was monitored for the use of vancomycin (medication used to treat infection). This deficient practice had the potential to result in Resident 20's unidentified side effects (an unwanted or unexpected result of a drug) of vancomycin use. Findings: During a record review of Resident 20's Admission Record, the Admission Record indicated the facility admitted Resident 20 on 8/22/2023, with diagnoses that included metabolic encephalopathy (change in how your brain works due to an underlying condition), pneumonia (lung infection) and unspecified (unconfirmed) cardiomyopathy (a group of heart muscle diseases that weaken the heart's ability to pump blood effectively throughout the body). During a record review of Resident 20's History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings) dated 1/24/2025, the H&P indicated Resident 20 had the capacity to understand and make decisions. During a record review of Resident 20's Minimum Data Set (MDS- a resident assessment tool) dated 11/20/2024, the MDS indicated Resident 20's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. During a record review of Resident 20's Physician Order dated 1/22/2025, the Physician Order indicated vancomycin hydrochloride intravenous (a medical procedure that involves inserting a needle or tube into a vein to deliver fluids, medications, or nutrient) solution, use 1000 milligram (mg- metric unit of measurement, used for medication dosage and/or amount) intravenously every 12 hours for pneumonia until 1/25/2025. During a record review of Resident 20's Intravenous Record (IV Record-a daily documentation record used by a licensed nurse to document medications given to a resident intravenously while on antibiotic [medications used to treat bacterial infections]) dated 1/2025, the IV Record indicated from 1/23/2025 to 1/25/2025, vancomycin was administered to Resident 20 twice a day at 9 a.m. and 9 p.m. During a record review of Resident 20's Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 1/2025, the MAR indicated no documented monitoring for the use and side effect of vancomycin. During a record review of Resident 20's Progress Notes dated 1/23/2025 to 1/25/2025, the Progress Notes indicated no documented monitoring for the use and side effect of vancomycin on 1/23/2025 from 3 p.m. to 11 p.m. and 1/24/2025 from 7 a.m. to 3 p.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 20's Daily Skilled Medicare Charting dated 1/23/2025, timed at 9:54 p.m., the Daily Skilled Medicare Charting indicated no vancomycin adverse side effect monitoring. During a concurrent interview and record review on 2/15/2025, at 11:30 a.m., with the Infection Preventionist (IP), Resident 20's Physician order dated 1/22/2025, Intravenous Record dated 1/2025, MAR dated 1/2025, and Progress Notes dated 1/23/2025 to 1/25/2025 were reviewed. The IP stated antibiotic monitoring for the use and side effect should be documented every shift in the Progress Notes. The IP stated there was no documented vancomycin monitoring on 1/24/2025 from 7 a.m. to 3 p.m. The IP stated the importance of monitoring for use of antibiotic was to monitor resident so the physician could be notified if resident had worsening condition. During an interview on 2/17/2025 at 1:49 p.m., with the DSD, the DSD stated residents on antibiotic are monitored for side effects and effectiveness of the medication. The DSD stated resident are monitored every shift for the first 72 hours. The DSD stated the monitoring should be documented in the Progress Notes. During an interview on 2/17/2025 at 5:13 p.m. with the DON, the DON stated monitoring for antibiotic is every shift and should be documented in the IV Record and in Daily Skilled Medicare Charting. The DON stated IP should also check the therapeutic effect (response after a treatment of any kind). The DON stated the importance of antibiotic monitoring was to check if resident was having any side effect like gastrointestinal symptoms and to inform the physician so medication can be stop or changed as needed. During a record review of facility's P&P titled, Antibiotic Stewardship-Review and Surveillance of Antibiotic Use and Outcomes dated 12/2016 and last reviewed on 1/14/2025, the P&P indicated, All resident antibiotic regimen will be documented on the facility-approved antibiotic surveillance tracking form. The information gathered will include: . k. outcome and l. adverse (unwanted undesirable effects that are possibly related to a drug) events. During a record review of facility's P&P titled, Surveillance for Infections dated 9/2023 and last reviewed on 1/14/2025, the P&P indicated, Documentation tools for the surveillance program . b. infection control worksheet (surveillance date sheet), nurse notes, or other related documentation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 43988 Based on observation, interview, and record review, the facility failed to maintain mechanical, electrical, and patient care equipment in safe operating condition for one (1) of three (3) sampled residents (Resident 32) reviewed under the Environmental Task when Resident 32's bed controller (device used to change the height and angle of the bed) cable was observed with chipped part at the base with the crews exposed. This deficient practice had the potential to place Resident 32 at risk for injury. Findings: During a review of Resident 32's Admission Record, the Admission Record indicated the facility originally admitted the resident on 1/24/2025 with diagnoses including muscle wasting and atrophy (loss of muscle mass and strength), dementia (a progressive state of decline in mental abilities), and generalized muscle weakness. During a review of Resident 32's History and Physical (H&P) dated 10/16/2024, the H&P indicated Resident 32 did not have the capacity to understand and make decisions. During a review of Resident 32's Minimum Data Set (MDS, a resident assessment tool), dated 12/15/2025, the MDS indicated Resident 32 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required supervision or touching assistance with eating; total assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a concurrent observation and interview on 2/15/2025 at 9:18 a.m. inside Resident 32's room with Treatment Nurse 1 (TN 1), TN 1 stated the base of Resident 32's bed control box was chipped with the screws exposed on both sides. TN 1 stated the maintenance department was responsible in rounding and changing any resident device or equipment that is in disrepair. TN 1 stated he was not sure when the maintenance department makes rounds and checks the rooms. TN 1 stated the staff was responsible to notify the maintenance for any equipment or device that is in disrepair. TN 1 stated the maintenance department will be notified to change Resident 32's bed control. TN 1 stated Resident 32's bed control should have been changed for the resident's safety as Resident 32 can get injured from the chipped base of the bed control box and the exposed screws. During an interview on 2/17/2025 at 4:55 p.m. with the Assistant Director of Nursing (ADON), the ADON stated if staff observed any equipment, devices, or furnishing in the room that is in disrepair such as broken, the maintenance department should be notified immediately to change the device, equipment, or furnishings. The ADON stated residents are provided with a safe, clean, functioning equipment, furnishings while residing in the facility as the facility is already their home. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/17/2025 at 5 p.m. with the Maintenance Supervisor (MS), the MS stated the maintenance department makes regular rounds of rooms and checks if all the call lights and bed controls are working and in good condition. The MS stated the maintenance department repairs and replaces them (call lights and bed controls) as needed if not working and/or broken. The MS stated the staff were supposed to notify him if a bed control is broken or the call light is not working so they can replace the equipment as soon as possible. During a review of the facility's policy and procedure (P&P) titled, Maintenance Service, last reviewed 1/14/2025, the P&P indicated the maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. The P&P further indicated the functions of maintenance personnel include maintaining the building in good repair and free from hazard. During a review of the facility's P&P titled, Homelike Environment, last reviewed 1/14/2025, the P&P indicated: - Residents are provided with a safe, clean, comfortable and homelike environment. - The facility staff and management maximizes, to the extent possible the characteristics of the facility that reflect a personalized, homelike setting such as a clean, safe, sanitary and orderly/clutter free environment.