

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2025
NAME OF PROVIDER OR SUPPLIER Valley Vista Nursing and Transitional Care LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6120 N. Vineland Ave 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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50961</p> <p>Based on observation, interview, and record review, the facility failed to maintain sanitary, orderly, and homelike environment for one of three sample residents (Resident 1) by failing to maintain cleanliness of Resident 1's floor.</p> <p>This failure had the potential to spread infection and negatively impact Resident 1's psychosocial well-being (refers to a resident's overall mental, emotional, and social health, encompassing aspects like happiness, life satisfaction, self-esteem, social functioning, and a sense of purpose).</p> <p>Cross Reference F880</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted on [DATE], and readmitted on [DATE], with diagnoses of chronic obstructive pulmonary disease (a chronic lung disease causing difficulty in breathing), systemic lupus erythematosus (a condition that can affect various parts of the body including the skin, joints, kidneys, and other organs, causing pain and inflammation), legal blindness (severe visual impairment), schizophrenia (a mental illness that is characterized by disturbances in thoughts), epilepsy (a neurological condition characterized by recurrent, sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares and loss of consciousness), and contracture of the left hand (a stiffening/shortening at any joint, that reduces the joint's range of motion(full movement potential of a joint)).</p> <p>During a review of Resident 1's History and Physical (H&P), dated 11/5/2024, the H&P indicated Resident 1 had the capacity to understand and make decisions.</p> <p>During a review of Resident 1's Care Plan (CP), dated 11/7/2024, the CP indicated Resident 1 was blind and was dependent on staff.</p> <p>(continued on next page)</p>

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: 555132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2025
NAME OF PROVIDER OR SUPPLIER Valley Vista Nursing and Transitional Care LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6120 N. Vineland Ave 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)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 2/7/2025, the MDS indicated Resident 1 had moderately impaired cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS also indicated Resident 1 required moderate assistance with toilet transfers, toilet hygiene, and maximal assistance with lower body dressing. The MDS indicated Resident 1 was always incontinent (having no or insufficient voluntary control) of urine and bowel movements.</p> <p>During a concurrent observation and interview on 4/2/2025 at 11:05 a.m. with Certified Nurse Assistant (CNA) 1 in Resident 1's room, food remains and utensils were observed on the floor next to the right side of Resident 1's bed. CNA 1 stated a plastic spoon with brown residue, a glass jar with brown residue, an upside-down brown plate, orange peels, and cut orange was observed on the floor next to the right side of Resident 1's bed. CNA 1 stated there were ants inside the glass jar and on the floor next to the right side of Resident 1's bed. CNA 1 stated it is important to keep Resident 1's room clean and prevent infection.</p> <p>During a concurrent observation and interview on 4/2/2025 at 11:25 a.m with CNA 1 in Resident 1's room, brown residue was observed on Resident 1's bedside commode. CNA 1 stated there was a dried fecal residue on the bedside commode. CNA 1 stated the bedside commode should have been cleaned to prevent spread of infection.</p> <p>During an interview on 4/3/2025 at 4:02 p.m. with the Director of Nursing (DON), the DON stated resident rooms should be kept clean and sanitary. The DON stated the facility failed to keep Resident 1's room clean, provide homelike environment, and maintain infection control measures which could potentially become a hazard to Resident 1's health.</p> <p>During a review of the facility-provided policy and procedure (P&P) titled, Quality of Life-Homelike Environment, last reviewed on 1/2025, the P&P indicated, Residents are provided with a safe, clean, comfortable and homelike environment 2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include a. Clean, sanitary and orderly environment</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2025
NAME OF PROVIDER OR SUPPLIER Valley Vista Nursing and Transitional Care LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6120 N. Vineland Ave 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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50961</p> <p>Based on interview and record review, the facility failed to implement resident-centered care plan for one of three sampled residents (Resident 1).</p> <p>This deficient practice could have delayed in providing Resident 1's care needs.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted on [DATE], and readmitted on [DATE], with diagnoses of chronic obstructive pulmonary disease (a chronic lung disease causing difficulty in breathing), systemic lupus erythematosus (a condition that can affect various parts of the body including the skin, joints, kidneys, and other organs, causing pain and inflammation), legal blindness (severe visual impairment), schizophrenia (a mental illness that is characterized by disturbances in thoughts), epilepsy (a neurological condition characterized by recurrent, sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares and loss of consciousness), and contracture of the left hand (a stiffening/shortening at any joint, that reduces the joint's range of motion(full movement potential of a joint)).</p> <p>During a review of Resident 1's History and Physical (H&P), dated 11/5/2024, the H&P indicated, Resident 1 had the capacity to understand and make decisions.</p> <p>During a review of Resident 1's Care Plan (CP), dated 12/5/2024, the CP indicated Resident 1 was non-compliant with weight management. The CP indicated Resident 1 would not suffer any consequences related to Resident 1's choices. The CP interventions included notifying physician of Resident 1's non-compliance with weight management.</p> <p>During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 2/7/2025, the MDS indicated Resident 1 had moderately impaired cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS also indicated Resident 1 was independent with eating and required supervision for oral hygiene.</p> <p>During an interview with Resident 1 on 4/2/2025 at 10:48 a.m., Resident 1 stated she had lost more than 50 pounds (lb-unit of measurement) since admission to the facility. Resident 1 stated her weight was measured upon admission. Resident 1 stated she refused monthly weight measurements.</p> <p>During a concurrent interview and record review on 4/3/25 at 9:21 a.m. with the Dietary Supervisor (DS), Resident 1' Monthly Weights Measurement Record was reviewed. The Monthly Weights Measurement Record indicated Resident 1's admitting weight on 11/5/2024 was 212 pounds (lb-unit of measurement), and in 4/2024 Resident 1's weight was 211 lbs. No weight measurements were recorded on 12/2024 to 3/2025. The DS stated Resident 1 refused to have her weights measured between 12/2024 to 3/2025 which were indicated on the Monthly Weights Measurement Record by an asterisk (*) marked for 12/2024 to 3/2025.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2025
NAME OF PROVIDER OR SUPPLIER Valley Vista Nursing and Transitional Care LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6120 N. Vineland Ave 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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/3/2025 at 4:02 p.m. with the Director of Nursing (DON), the DON stated licensed staff were responsible for communicating Resident 1's noncompliance with weight measurement to the physician. The DON stated facility could not provide documented evidence of physician communication regarding Resident 1's weight measurement refusal. The DON stated the facility failed to implement Resident 1's care plan. The DON stated Resident 1 could have potentially experienced a change in her condition and weight loss that was not identified. The DON stated facility did not have a policy addressing resident's care plan implementation.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2025
NAME OF PROVIDER OR SUPPLIER Valley Vista Nursing and Transitional Care LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6120 N. Vineland Ave 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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50961</p> <p>Based on interview and record review the facility failed to ensure residents received treatment and care in accordance with professional standards of practice to meet the resident's physical, mental, and psychosocial (relating to teh interrelation of social factors and indivudial thoughts and behavior) needs for one of three sampled residents (Resident 1) by failing to:</p> <ol style="list-style-type: none"> Administer medications and treatments as ordered by the physician. Provide Resident 1 with enough Oxygen supply to last during clinic appointments. <p>These deficient practices had the potential to place Resident 1 at risk for unrelieved shortness of breath, respiratory complications, and negatively affect Resident 1's life.</p> <p>Findings:</p> <p>a. During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted on [DATE], and readmitted on [DATE], with diagnoses of chronic obstructive pulmonary disease (a chronic lung disease causing difficulty in breathing), systemic lupus erythematosus (a condition that can affect various parts of the body including the skin, joints, kidneys, and other organs, causing pain and inflammation), legal blindness (severe visual impairment), schizophrenia (a mental illness that is characterized by disturbances in thoughts), epilepsy (a neurological condition characterized by recurrent, sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares and loss of consciousness), and contracture of the left hand (a stiffening/shortening at any joint, that reduces the joint's range of motion(full movement potential of a joint)).</p> <p>During a review of Resident 1's History and Physical (H&P), dated 11/5/2024, the H&P indicated, Resident 1 had the capacity to understand and make decisions.</p> <p>During a review of Resident 1's Care Plan (CP), initiated on 11/5/2024, the CP indicated Resident 1 had the potential for episodes of shortness of breath and required use of oxygen.</p> <p>During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 2/7/2025, the MDS indicated Resident 1 had moderately impaired cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS also indicated Resident 1 required moderate assistance with toilet transfers, toilet hygiene, and maximal assistance with lower body dressing.</p> <p>During a review of Resident 1's Order Summary Report, the report indicated the following physician's order:</p> <p>-1/20/2025: Aquaphor External Ointment (medication used to create a barrier on the skin, help to heal and protect dry, cracked or irritated skin) Apply to nostril (nose) area topically every day shift for skin maintenance of dry skin apply to each nostril area.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2025
NAME OF PROVIDER OR SUPPLIER Valley Vista Nursing and Transitional Care LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6120 N. Vineland Ave 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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-3/2/2025: Albuterol Sulfate (medication used to prevent and treat wheezing, difficulty breathing, chest tightness, and coughing caused by lung diseases) Inhalation Nebulization (the process of converting liquid medication into a fine mist or aerosol, allowing it to be inhaled directly into the lungs for treatment of respiratory conditions) Solution 5 milligram/milliliter (mg/ml-a unit of measurement) 0.5 percent (% - per hundred) 1 unit inhale orally via nebulizer (medical device that converts liquid medication into a fine mist, which is then inhaled into the lungs) four times a day for COPD.</p> <p>-3/2/2025: Symbicort Inhalation (medication used to reduce inflammation and open the airways to help improve breathing and prevent symptoms such as shortens of breath) Aerosol (a suspension of tiny solid or liquid particles in a gas, typically air 160-4.5 microgram/ACT (mcg/ACT-a unit of measurement) 2 puffs inhale orally two times a day for COPD and rinse mouth after use.</p> <p>During an interview on 4/2/2015 at 10:48 a.m. with Resident 1, Resident 1 stated feeling frustrated because she was not receiving timely breathing treatments and skin treatment as ordered by the physician.</p> <p>During a concurrent interview and record review on 4/2/2025 at 10:04 a.m. with LVN 1, Resident 1's Treatment Administration Record (TAR), dated 3/025 was reviewed. The TAR indicated on 3/9/2025, 3/16/2025, 3/23/2025, 3/30/3035, there were no licensed staff initials in the box for Resident 1's Administer Aquaphor External Ointment, to demonstrate the treatments were administered. LVN 1 stated there was no documentation on the TAR dated 3/2025 that indicated Resident 1 received the Administer Aquaphor External Ointment on 3/9/2025, 3/16/2025, 3/23/2025, and 3/30/3035.</p> <p>During a concurrent interview and record review on 4/3/1015 at 3:36 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 1's Medication Administration Record (MAR), dated 3/2025 was reviewed. The MAR indicated, on 3/28/2025 for the 9 p.m. administration time, there was no licensed staff initials in the box for Resident 1's Symbicort Inhalation Aerosol 160-4.5mcg/act, to demonstrate the medication was administered. The MAR also indicated, on 3/28/2025 for the 5 p.m. and 10 p.m. administration times, there were no licensed staff initials in the box for Resident 1's Albuterol Sulfate Inhalation Nebulization Solution 5mg/ml), to demonstrate the medication was administered. LVN 1 stated there was no documentation on the MAR dated 3/2025 that indicated Resident 1 received the Sympicort Inhalation Aerosol 160-4.5mcg/act on 3/28/2025 at 9 p.m. LVN 1 also stated there was no documentation on the MAR dated 3/2025 that indicated Resident 1 received the Albuterol Sulfate Inhalation Nebulization Solution 5mg/ml 1 unit on 3/28/2025 at 5 p.m. and 10 p.m. LVN 1 stated the failure to administer medications could have potentially caused Resident 1 to experience shortness of breath.</p> <p>During an interview on 4/3/2024 at 4:02 p.m. with the Director of Nursing (DON), the DON stated the facility failed to administer Resident 1's medications and treatments as ordered by the physician. The DON stated failure to follow physicians' medication and treatment orders had the potential to jeopardize Resident 1's safety potentially causing respiratory complications and desaturation (a decrease in the oxygen saturation of the blood).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2025
NAME OF PROVIDER OR SUPPLIER Valley Vista Nursing and Transitional Care LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6120 N. Vineland Ave 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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility-provided policy and procedure (P&P) titled, Administering Medications, last reviewed on 1/2025, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed .4. Medications are administered in accordance with prescriber orders, including any required time frame 23. As required or indicated for the medication, the individual administering the medication records in the resident's medical record: a. the date and time the medication was administered . g. the signature and title of the person administering the drug . 24. Topical medications used in treatments are recorded on the resident's treatment record (TAR).</p> <p>b. During a review of Resident 1's Order Summary Report, the report indicated the following physician's orders:</p> <p>-12/10/2024: Oxygen at 4 to 5 Liters (L-unit of measurement) per minute via nasal cannula (a device that gives additional oxygen through the nose) continuously to keep Oxygen saturation (O2 sat-measurement of how much oxygen blood is carrying as a percentage of the maximum it could carry) > (symbol for greater than) 90% every shift for COPD.</p> <p>- 3/20/2025: Patient to be at cardiology (the medical specialty focused on the diagnoses, treatment, and prevention of diseases and disorders of the heart and blood vessels) office on 4/3/2025 at 2:00 p.m. to remove a heart monitor and needs transportation to be arranged.</p> <p>During a concurrent observation and interview on 4/2/2025 at 10:48 a.m. with Resident 1 in Resident 1's room, Resident 1 was observed receiving oxygen via nasal cannula at 4 L per min. Resident 1 stated during several clinic appointments, the facility provided Resident 1 with one oxygen tank which did not contain enough oxygen to last until Resident 1 returned to the facility causing shortness of breath.</p> <p>During an interview on 4/3/2025 at 11:35 a.m. with Certified Nurse Assistant (CNA) 2, CNA 2 stated she worked as a Social Services Assistant until 4/2025. CNA 2 stated the Social Worker (SW) arranged transportation for Resident 1's clinic appointments. CNA 2 stated the licensed nurse would provide Resident 1 with one oxygen tank for Resident 1's clinic appointments.</p> <p>During a concurrent observation and interview on 4/3/2025 at 10:04 a.m. with Licensed Vocational Nurse (LVN) 1 in the Oxygen Storage Room, one oxygen tank was observed to contain 2,000 pounds per square inch (psi-unit of pressure used to measure the amount of oxygen compressed and stored within the tank, indicating how much oxygen remains) of oxygen. LVN1 stated Resident the type of the oxygen tank observed was provided to Resident 1 during clinic appointments. LVN 1 stated the oxygen tank observed contained 2000 psi of oxygen. LVN 1 stated Resident 1 received oxygen via nasal cannula at 4 to 5L per min.</p> <p>During an interview on 4/3/2025 at 12:25 p.m with LVN 1, LVN 1 stated Resident 1 was scheduled for a clinic appointment on 4/3/2025 at 1 p.m. LVN 1 stated Resident 1 would be provided with one oxygen tank.</p> <p>During a concurrent observation and interview on 4/3/2025 at 12:32 p.m. with Resident 1 in Resident 1's room, one oxygen E tank was observed near the entrance to the room. Resident 1 stated she was scheduled for a cardiology office appointment and the oxygen tank was brought to her room to prepare for transfer.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2025
NAME OF PROVIDER OR SUPPLIER Valley Vista Nursing and Transitional Care LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6120 N. Vineland Ave 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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/3/2025 at 12:37 p.m. with the Oxygen Provider (OP), the OP stated facility received two types of oxygen tanks: E tanks that contained 24 cubic feet (unit of measurement) of oxygen and H tanks which contained 2024 cubic of oxygen. The OP stated E tanks which were suitable for transportation contained 680L of oxygen which was equivalent to 2,000 psi and would last for a maximum of two hour for a Resident who uses 4 to 5L of oxygen per minute.</p> <p>During an interview on 4/3/2025 at 1:05 p.m. with the Director of Nursing (DON), the DON stated before transfer to cardiology clinic appointment, LVN 1 was instructed to provide Resident 1 with second oxygen E tank.</p> <p>During a follow up interview on 4/3/2025 at 4:02 p.m. with the DON, the DON stated facility did not have a facility plan or policy addressing providing residents with oxygen during transportation. The DON stated facility's failure to provide Resident 1 with enough oxygen to last during clinic visits could have potentially endangered Resident 1's life.</p> <p>During an interview on 4/3/2025 at 4:15 p.m. with Resident 1, Resident 1 stated on 4/3/2025 at approximately 3:15 p.m. while at the clinic, Resident 1 had to switch to the second oxygen tank since the fist oxygen tank she used ran out of oxygen (one tank of Oxygen is not enough to last while Resident 1 was out of the facility).</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2025
NAME OF PROVIDER OR SUPPLIER Valley Vista Nursing and Transitional Care LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6120 N. Vineland Ave 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50961</p> <p>Based on observation, interview, and record review, the facility failed to implement and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one of three sampled residents (Resident 1) by:</p> <ol style="list-style-type: none"> 1. Failing to maintain clean and sanitary floors in Resident 1's room. 2. Failing to keep Resident 1's bedside commode (portable toilet-a chair with a bucket or receptacle designed to be used by people with limited mobility who cannot easily reach a regular bathroom) clean and disinfected. <p>This deficient practice had the potential to place Resident 1 at risk for acquiring infection and negatively affect Resident 1's quality of life.</p> <p>Cross Reference with F584</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted on [DATE], and readmitted on [DATE], with diagnoses of chronic obstructive pulmonary disease (a chronic lung disease causing difficulty in breathing), systemic lupus erythematosus (a condition that can affect various parts of the body including the skin, joints, kidneys, and other organs, causing pain and inflammation), legal blindness (severe visual impairment), schizophrenia (a mental illness that is characterized by disturbances in thoughts), epilepsy (a neurological condition characterized by recurrent, sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares and loss of consciousness), contracture of the left hand (a stiffening/shortening at any joint, that reduces the joint's range of motion(full movement potential of a joint)).</p> <p>During a review of Resident 1's History and Physical (H&P), dated 11/5/2024, the H&P indicated, Resident 1 had the capacity to understand and make decisions.</p> <p>During a review of Resident 1's Care Plan (CP), dated 11/7/2024, the CP indicated Resident 1 was blind and was dependent on staff.</p> <p>During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 2/7/2025, the MDS indicated Resident 1 had moderately impaired cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS also indicated Resident 1 required moderate assistance with toilet transfers, toilet hygiene, and maximal assistance with lower body dressing. The MDS indicated Resident 1 was always incontinent of urine and bowel movements.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2025
NAME OF PROVIDER OR SUPPLIER Valley Vista Nursing and Transitional Care LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6120 N. Vineland Ave 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 4/2/2025 at 11:05 a.m. with Certified Nurse Assistant (CNA) 1 in Resident 1's room, food remains and utensils were observed on the floor next to the right side of Resident 1's bed. CNA 1 stated a plastic spoon with brown residue, a glass jar with brown residue, an upside-down brown plate, orange peels, and cut orange was observed on the floor next to the right side of Resident 1's bed. CNA 1 stated there were ants inside the glass jar and on the floor next to the right side of Resident 1's bed. CNA 1 stated it is important to keep Resident 1's room clean to prevent infections.</p> <p>During a concurrent observation and interview on 4/2/2025 at 11:25 a.m with CNA 1 in Resident 1's room, brown residue was observed on Resident 1's bedside commode. CNA 1 stated there was a dried fecal residue on the bedside commode. CNA 1 stated the bedside commode should have been cleaned to prevent spread of infection.</p> <p>During an interview on 4/3/2025 at 11:45 a.m. with the MDS Coordinator who was covering for the Infection Preventionist (IP), the MSD Coordinator stated facility failed to keep Resident 1's room clean and sanitary which could potentially jeopardize Resident 1's health by causing infection to Resident 1.</p> <p>During an interview on 4/3/2025 at 4:02p.m. with the Director of Nursing (DON), the DON stated resident rooms should be kept clean and sanitary. The DON stated the facility failed to keep Resident 1's room clean, provide homelike environment, and maintain infection control measures which could potentially become a hazard to Resident 1's health.</p> <p>During a review of the facility-provided P&P titled, Cleaning and Disinfection of Resident-Care Items and Equipment, last reviewed on 1/2025, the P&P indicated Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CSC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard .Semi-critical items consist of items that may come in contact with mucous membranes or non-intact skin Such devices should be free from all microorganisms</p>		