| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555132 | A. Building<br>B. Wing | 05/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Valley Vista Nursing and Transitional Care LLC | 6120 N. Vineland Ave<br>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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50961<br><br>Based on interview and record review, the facility failed to report within two hours an incident of an alleged abuse (willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish) for two of three sampled residents (Resident 1 and 2). The abuse incident happened on 5/1/2025 at 7:30 p.m. and was reported to the State Survey Agency on 5/2/2025.<br><br>This deficient practice had the potential to result in unidentified abuse in the facility and placed Resident 1 and Resident 2 at risk of further abuse.<br><br>Findings:<br><br>a. During a review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 12/23/2024 with the following diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (feeling of anxiousness that affects daily life), and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality)<br><br>During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 3/26/2025, the MDS indicated the resident had impaired cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks).<br><br>During an interview on 5/16/2025 at 9:40a.m. with Resident 1, Resident 1 stated Resident 2 approached her (unable to provide date of the incident) in the smoking patio (designated outdoor smoking area) and stated Resident 1's dress was open in the back. Resident 1 stated Resident 2 hit Resident 1's arm.<br><br>b. During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with the following diagnoses including depression ( a mood disorder that causes a persistent feeling of sadness and loss of interest), schizophrenia (a mental illness that is characterized by disturbances in thoughts), anemia (a condition where the body does not have enough healthy red blood cells).<br><br>(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 |
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| Valley Vista Nursing and Transitional Care LLC | 6120 N. Vineland Ave<br>North Hollywood, CA 91606 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of Resident 2's MDS, dated [DATE], the MDS indicated the resident had intact cognitive functioning. MDS indicated Resident 2 required moderate assistance to wheel self at least 50 feet (ft, unit of distance measurement).<br><br>During a review of Resident 2's Care Plan (CP), initiated on 5/2/2025, the CP indicated Resident 2 claimed she was hit in the face by another resident. The CP also indicated Resident 2 was at risk for emotional distress.<br><br>During an interview on 5/16/2025 at 9:27a.m. with Resident 2, Resident 2 stated she approached Resident 1 in the smoking patio to tell her that her dress was open when Resident 1 hit her face. Resident 2 stated Resident 1 tried to throw a slipper at her when AA 1 caught the slipper and helped her back inside the facility. Resident 2 stated on 5/2/2025, she informed the Administrator Resident 1 hit her in the smoking patio.<br><br>During an interview on 5/16/2025 a.m. with Activities Aide (AA) 1, AA 1 stated on 5/1/2025 at approximately 7:30 p.m., he heard Resident 1 and Resident 2 screaming at each other in the smoking patio. AA 1 stated Residents' speech was unintelligible. AA 1 stated Resident 2 approached Resident 1 near the entrance of the smoking patio and attempted to put her arm around Resident 1's shoulder, while Resident 1. AA 1 stated he approached Residents (Resident 1 and Resident 2) and moved Resident 2 away from Resident 1 before Resident 2 could touch Resident 1. AA 1 stated he stopped Resident 1 from throwing her slipper at Resident 2. AA 1 stated he assisted Resident 2 inside the facility and left her in her wheelchair near the nursing station. AA 1 stated he did report the incident to the facility staff.<br><br>During an interview on 5/16/2025 at 2:30 p.m. with the Administrator, the Administrator stated on 5/2/2025, at approximately 9:30 a.m., Resident 2 approached the Administrator and reported that on 5/1/2025 Resident 1 swung her arm at Resident 2. The Administrator stated he was not notified of the incident by the facility staff. The Administrator stated AA 1 should have reported the incident to the Administrator or supervisor. The Administrator stated the failure to report the incident had the potential to cause psychological and physical distress for Residents 1 and 2 and place Residents (Resident 1 and Resident 2) at risk of abuse. The Administrator stated he reported the abuse allegation to the State Survey Agency on 5/2/2025 approximately an hour after Resident 2 reported the incident to him (Administrator).<br><br>During a review of the facility's policy and procedure (P&P) titled, Reporting Abuse to Facility Management, last reviewed on 1/2025, the P&P indicated, It is the responsibility of our employees, facility consultants, Attending Physicians, family members, visitors, etc., to promptly report any incident or suspected incident of neglect or resident abuse .To help with recognition of incidents of abuse, the following definitions of abuse are provided: Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Verbal abuse is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance to describe residents, regardless of their age, ability to comprehend, or disability . 4. Employees, facility consultants and /or Attending Physicians must immediately report any suspected abuse or incident of abuse to the Director of Nursing Services. In the absence of the Director of Nursing Services such reports may be made to the Nurse supervisor on duty. |