STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555132	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Vista Nursing and Transitional Care LLC	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)
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. 46445 Based on interview and record review, the facility failed to develop and implementa comprehensive, person-centered care plan with measurable objectives and interventions for one of four sampled residents (Resident 2) when the facility did not create and implement a care plan that addressed Resident 2's refusal of indwelling urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) care. This deficient practice placed Resident 2 at risk for not receiving the necessary services and assistance that can result in resident injury or serious condition. Findings: During a review of Resident 2's Admission Record, the Admission Record indicated the facility admitted the resident on 4/19/2025 with diagnoses including epilepsy (a condition that affects the brain and causes frequent seizures [sudden, uncontrolled body movements and changes in behavior that occurs because of abnormal electrical activity in the brain]), Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), and retention of urine. During a review of Resident 2's History and Physical (H&P), dated 4/20/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 4/25/2025, the MDS indicated Resident 2's cognitive (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making were moderately impaired. The MDS indicated Resident 2 was dependent on facility staff on toileting hygiene. The Bladder and Bowel section in the MDS indicated Resident 2 had an indwelling catheter. During a review of Resident 2's Progress Notes, dated 5/15/2025, the Progress Notes indicated Licensed Vocational Nurse (LVN) 5 documented Resident 2 refused the disposable brief change three times. (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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/20/2025 at 2:38 p.m. with the MDS Nurse (MDSN), Resident 2's care plans were reviewed and the MDSN stated care plans were designed to guide the facility staff on the care provided for the residents. The MDSN stated Resident 2's Care Plans did not indicate a care plan was created addressing the resident's refusal of urinary catheter care and toileting hygiene care. The MDSN stated without a care plan, Resident 2's needs will not be addressed. During an interview on 5/20/2025 at 3:45 p.m. with the Director of Nursing (DON), the DON stated resident care plans were designed to address the residents' problems. The DON stated care plans should be specific and resident centered. The DON stated a Change of Condition (COC) form would be initiated for a resident that refused care. The DON stated a care plan was not initiated after Resident 2 refused toileting and indwelling catheter care. The DON stated the facility failed to ensure care plans were created to address Resident 2's refusal of care. During a review of the facility's policy and procedure (P&P) titled, Care Plans - Comprehensive, last reviewed on 1/2025, the P&P indicated an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychological needs is developed for each resident. The P&P indicated each resident's comprehensive care plan is designed to incorporate identified problem areas .incorporate risk factors associated with identified problems . The P&P indicated assessments of residents are ongoing, and care plans are revised as information about the resident and the resident's condition change. During a review of the facility's P&P titled, Change in a Resident's Condition or Status, last reviewed on 1/2025, the P&P indicated the nurse supervisor or charge nurse will notify the resident's attending physician or on-call physician when there has been . f. refusal of treatment or medications (two or more consecutive times).

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 46445 Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 2) with indwelling urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) received proper care and services by failing to: 1. Ensure Resident 2's indwelling urinary catheter had an order. 2. Ensure Resident 2 was monitored for the presence of urinary tract infection (UTI- an infection in the bladder/urinary tract). 3. Ensure licensed nurses provided and documented Resident 2's urinary catheter care. These deficient practices had the potential to cause Resident 2 urinary catheter-associated complications including UTI, discomfort, and pain. Findings: During a review of Resident 2's Admission Record, the Admission Record indicated the facility admitted the resident on 4/19/2025 with diagnoses including epilepsy (a condition that affects the brain and causes frequent seizures [sudden, uncontrolled body movements and changes in behavior that occurs because of abnormal electrical activity in the brain]), Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), and retention of urine. During a review of Resident 2's History and Physical (H&P), dated 4/20/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 4/25/2025, the MDS indicated Resident 2's cognitive (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making were moderately impaired. The MDS indicated Resident 2 was dependent on facility staff on toileting hygiene. The Bladder and Bowel section indicated Resident 2 had an indwelling catheter. During a review of Resident 2's Care Plan on urinary catheter, initiated on 5/10/2025, the Care Plan indicated the resident had a Foley (a brand name of an indwelling urinary device) catheter related to urinary retention. The Care Plan interventions indicated urinary catheter care every shift, provide good perineal care during episodes of bowel elimination, and observe urine for signs and symptoms of infection such as foul odor, abnormal urine color, and presence of blood. The interventionsindicated to notify the Attending Physician (MD) promptly. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's Care Plan on infection, initiated on 5/12/2025, the Care Plan indicated the resident was at risk for infection related to contributing factors and diagnoses of history of UTI and use of indwelling catheter for urinary elimination. The Care Plan interventions indicated to evaluate for urinary complaint, to evaluate urine characteristics, manage indwelling catheters to minimize risk of infection, and to monitor for signs and symptoms of infection. During a concurrent interview and record review with Licensed Vocational Nurse (LVN) 2 on 5/20/2025 at 10:24 a.m., Resident 2's Physician Orders, dated 5/20/2025, were reviewed and LVN 2 stated Resident 2 had no urinary catheter order when the resident was readmitted from General Acute Care Hospital (GACH) 1 on 5/14/2025. LVN 2 stated a physician's order for urinary catheter and urinary catheter care and monitoring was required to reflect in Resident 2's Treatment Administration Record (TAR). Resident 2's TAR, dated 5/1/2025 to 5/31/2025, was reviewed and LVN 2 stated Resident 2's TARindicated there was no urinary catheter care and monitoring provided for Resident 2. Resident 2's Care Plan for Foley catheter related to urinary retention, initiated 5/10/2025, was reviewed and LVN 2 stated Resident 2's care plan interventions were not followed. LVN 2 stated Resident 2 had the potential to develop UTI. During an interview on 5/20/2025 at 3:45 p.m. with the Director of Nursing (DON), the DON stated Resident 2 was readmitted from GACH 1 with an indwelling urinary catheter. The DON stated Resident 2's urinary catheter, catheter care, and monitoring were not documented in the resident's medical records. The DON stated the facility failed to ensure residents with indwelling urinary catheter were assessed and monitored. The DON stated the facility failed to document the assessments and monitoring done for Resident 2. The DON stated Resident 2 had the potential to develop UTI. During a review of the facility's policy and procedure (P&P) titled, Catheter Care, Urinary, last reviewed on 1/2025, the P&P indicated the purpose .to prevent catheter-associated urinary tract infections. The P&P indicated to observe the resident for complications associated with urinary catheters . b. check the urine for unusual appearance, c. notify the physician or supervisor in the event of bleeding, or if the catheter is accidentally removed . e. observe for other signs and symptoms of urinary tract infection or urinary retention. During a review of the facility's P&P titled, Charting and Documentation, last reviewed on 1/2025, the P&Pindicated documentation of procedures and treatments shall include care-specific details and shall include . the date and time the procedure or treatment was provided, the assessment and any unusual findings obtained during the procedure or treatment, and how the resident tolerated the procedure or treatment.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 46445 Based on observation, interview, and record review, the facility failed to provide necessary respiratory care and services for one of three sampled residents (Resident 1) by failing to: 1. Ensure Resident 1's oxygen tubing was dated when it was changed. 2. Ensure Resident 1's oxygen tubing was kept inside an oxygen supplies bag when not in use. 3. Ensure Resident 1's oxygen tubing was not touching unclean surfaces. These deficient practices had the potential for Resident 1 to develop respiratory (organs and structures in the body that allow a person to breathe) diseases or infections. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 11/5/2024 with diagnoses including chronic obstructive pulmonary disease (COPD - a lung disease characterized by long term poor airflow), systemic lupus erythematosus (a disease where the immune system of the body mistakenly attacks healthy tissues and organs, leading to inflammation and damage), and type two diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 5/9/2025, the MDS indicated Resident 1's cognition (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) was moderately impaired. During a review of Resident 1's Physician Order, dated 4/30/2025, the Physician Order indicated oxygen at two liters per minute (unit of measurement) every shift. During a review of Resident 1's Physician Order, dated 5/4/2025, the Physician Order indicated oxygen tubing and humidifier change one time a day every Sunday. During a concurrent observation and interview on 5/21/2025 at 9:16 a.m. with the Quality Assurance Nurse (QAN) inside Resident 1's room, Resident 1's nasal cannula (also known as oxygen cannula, a medical device that delivers supplemental oxygen through the nose) tubing touched the floor while connected to the resident and oxygen concentrator (a medical device that gives a person extra oxygen). The QAN stated Resident 1's nasal cannula did not have a date when it was last changed. Resident 1's other oxygen mask and tubing was on top of an overbed table. The QAN stated Resident 1's oxygen equipment should be dated and stored in a dated plastic bag when not in use. The QAN stated the oxygen nasal cannula tubing and mask should not touch the floor or any unclean surfaces. The QAN stated Resident 1 had the potential to acquire infections from unclean and contaminated oxygen equipment such as the nasal cannulas. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/2025 at 9:35 a.m. with the Director of Nursing (DON), the DON stated oxygen cannulas, oxygen masks, and oxygen supply bags should be changed every seven days. The DON stated Resident 1's oxygen supplies should be dated to indicate when the supplies were last changed. The DON stated Resident 1's oxygen cannulas should be inside the dated oxygen supply bag when not in use. The DON stated Resident 1's undated oxygen supplies that were touching unclean surfaces had the potential to cause Resident 1's respiratory infection. The DON stated the facility failed to ensure Resident 1's oxygen supplies were dated and did not touch unclean surfaces. During a review of the facility's policy and procedure (P&P) titled Departmental (Respiratory Therapy) Prevention of Infection, last reviewed on 1/2025, the P&Pindicated the purpose was to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. The Infection Control Considerations Related to Oxygen Administration section indicated . 7. Change the oxygen cannula and tubing every seven days or as needed, 8. Keep the oxygen cannula and tubing used PRN (as needed) in a plastic bag when not in use. The P&P indicated to store the circuit in a plastic bag, marked with date and resident's name.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 46445 Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 1) was free from significant medication errors by failing to ensure the physician orders were followed. The facility failed to ensure Resident 1's cephalexin oral tablet (a medication, taken by mouth, used to treat bacterial infections) 500 milligrams (mg - unit of measurement) was administered at the scheduled time on multiple dates. This deficient practice placed Resident 1 at risk for untreated infections and had the potential for the development of multidrug-resistant organisms (MDRO - bacteria that becomes resistant to multiple types of antibiotics [a medication that inhibit the growth of bacteria], making them harder to treat). Findings: During a review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 11/5/2024 with diagnoses including chronic obstructive pulmonary disease (COPD - a lung disease characterized by long term poor airflow), systemic lupus erythematosus (a disease where the immune system of the body mistakenly attacks healthy tissues and organs, leading to inflammation and damage), and type two diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 5/9/2025, the MDS indicated Resident 1's cognition (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) was moderately impaired. During a review of Resident 1's Progress Notes, dated 5/3/2025, the Progress Notes indicated Resident 1 returned from the General Acute Care Hospital (GACH) 1 with a diagnosis of bladder infection. During a review of Resident 1's Physician Orders, dated 5/5/2025, the Physician Orders indicated to discontinue Macrobid oral capsule (a medication, taken by mouth, used to treat bacterial infections) 100 mg two times a day for bladder infection. During a review of Resident 1's Physician Orders, dated 5/5/2025, the Physician Orders indicated cephalexin oral tablet 500 mg four times a day for seven days for bladder infection. During a concurrent interview and record review on 5/20/2025 at 2:38 p.m. with the MDS Nurse (MDSN), Resident 1's Medication Administration History, dated 5/5/2025 to 5/11/2025, was reviewed and the Medication Administration History indicated Resident 1 was scheduled to receive cephalexin 500 mg at 9 a. m., 12 p.m., 5 p.m., and 9 p.m. every day. The MDSN stated Resident 1's cephalexin 500 mg may be given one hour before or one hour after the medication's scheduled administration time. The Medication Administration History indicated Resident 1 received the scheduled cephalexin 500 mg late on the following dates and times: a. On 5/5/2025 at 2 p.m., one hour after the allowed administration time. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. On 5/5/2025 at 6:47 p.m., 47 minutes after the allowed administration time. c. On 5/7/2025 at 6:55 p.m., 55 minutes after the allowed administration time. d. On 5/8/2025 at 1:43 p.m., 43 minutes after the allowed administration time. e. On 5/8/2025, Resident 1's scheduled medication at 5 p.m. and 9 p.m. were both administered at 11:37 p.m. f. On 5/9/2025 at 2:21 p.m., one hour and 21 minutes after the allowed administration time. g. On 5/9/2025 at 7:33 p.m., one hour and 33 minutes after the allowed administration time. The next dose was administered at 8:08 p.m., 35 minutes after the last dose was administered. h. On 5/10/2025 at 1:38 p.m., 38 minutes after the allowed administration time. The MDSN stated late administration of Resident 1's medication had the potential for the bacteria to become resistant to the medication and lead to ineffective treatment of Resident 1's infection. During an interview on 5/20/2025 at 3:45 p.m. with the Director of Nursing (DON), the DON stated medications should be administered within the allowed administration time, which was one hour before or one hour after the scheduled administration time. The DON stated Resident 1's cephalexin was not administered on time on multiple dates and times. The DON stated Resident 1's medication not administered on time had the potential to be ineffective in treating the resident's infection. The DON stated the facility failed to ensure Resident 1's medication was administered on time as ordered by the physician. During an interview on 5/20/2025 at 4:15 p.m. with the facility's Pharmacist (Pharm) 1, Pharm 1 stated a medication such as cephalexin 500 mg administered with a short interval between the doses or two doses administered at the same time, had the potential to cause a resident abdominal pain and diarrhea. During a review of the current facility-provided policy and procedure (P&P) titled, Administering Medications, last reviewed on 1/2025, the P&P indicated medications shall be administered in a safe and timely manner, and as prescribed. Medications must be administered in accordance with the orders, including any required time frame Medications must be administered within one hour of their prescribed time If a drug (medication) is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the medication administration record (MAR) space provided for that drug and dose.