

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 06/04/2025
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse (the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish) for two of three sampled residents (Resident 2 and Resident 3). On 5/31/2025 at 9 p.m., Resident 2 and Resident 3 had a verbal altercation (an angry argument or disagreement expressed through words) in the smoking patio that led to a physical altercation (a confrontation or fight involving physical contact or force) where Resident 3 grabbed Resident 2 by the neck to choke Resident 2.</p> <p>This deficient practice resulted in Resident 2 being subjected to physical abuse by Resident 3 while under the care of the facility. Resident 2 stated when Resident 3 grabbed her (Resident 2) neck, Resident 2 ended up landing on the right side of her (Resident 2) body with her (Resident 2) chair on the ground. The incident made Resident 2 feel shocked (emotionally or physically disturbed; upset), scared, and experienced pain on her (Resident 2) right knee with a pain intensity of five out of 10 on the pain scale (a scale used to measure pain, typically from 0 to 10, where 0 represents no pain and 10 represents the worst possible pain).</p> <p>Findings:</p> <p>During a review of Resident 2's admission Record, the admission Record indicated the facility initially admitted Resident 2 on 4/27/2020 and readmitted on [DATE] with diagnoses including osteoarthritis (a degenerative joint disease, in which the tissues in the joint break down over time) and hypertension (high blood pressure, which is when the force of blood against the artery walls is too high).</p> <p>During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 3/31/2025, the MDS indicated Resident 2 had moderately impaired thought process (when individuals experience noticeable decline in cognitive abilities, such as memory, language, and problem-solving) and required moderate assistance from staff to complete activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily).</p> <p>During a review of Resident 2's History and Physical Examination, dated 10/29/2024, the History and Physical Examination indicated Resident 2 had the capacity to understand and make decisions.</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
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 2's Change in Condition (a noticeable alteration in a resident's health or physical state) Evaluation, dated 5/31/2025, the Change in Condition Evaluation indicated Resident 2 claimed an allegation of abuse. The Change in Condition Evaluation indicated Resident 2 stated Resident 3 caused Resident 2 to fall at the smoking patio.</p> <p>During a review of Resident 2's Post Fall Evaluation, dated 5/31/2025, the Post Fall Evaluation indicated Resident 2 alleged another resident (Resident 3) caused her (Resident 2) to fall at the smoking patio.</p> <p>During a review of Resident 2's Pain Assessment, dated 5/31/2025, the Pain Assessment indicated Resident 2 verbalized complaints of pain with a pain intensity of five out of 10 on the pain scale. The Pain Assessment indicated Resident 2 had mild pain in her right knee.</p> <p>During a review of Resident 3's admission Record, the admission Record indicated the facility admitted Resident 3 on 3/5/2025, with diagnoses including encephalopathy (brain is not working right due to some kind of injury or disease) and chronic obstructive pulmonary disease (airflow obstruction, making it difficult to breathe).</p> <p>During a review of Resident 3's History and Physical Examination, dated 5/26/2025, the History and Physical Examination indicated Resident 3 had the capacity to make decisions for ADLs.</p> <p>During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 had moderately impaired thought processes and required moderate assistance from staff to complete ADLs. The MDS indicated Resident 3 required supervision during sit to lying, chair/bed to chair transfer, toilet transfer, shower transfer, walking 10 feet, and walking 50 feet with two turns.</p> <p>During a review of Resident 3's Change in Condition Evaluation, dated 5/31/2025, the Change in Condition Evaluation indicated Resident 2 stated Resident 3 caused her (Resident 2) to fall at the smoking patio.</p> <p>During a review of Resident 4's admission Record, the admission Record indicated the facility initially admitted Resident 4 on 8/31/2016 and readmitted on [DATE] with a diagnosis of hypertension and chronic obstructive pulmonary disease.</p> <p>During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4 had intact thought process (a person's thinking is logical, sequential, and goal-directed, without excessive or disorganized rambling or shifting between topics) and was able to perform ADLs independently.</p> <p>During a review of Resident 4's History and Physical Examination, dated 10/25/2024, the History and Physical Examination indicated Resident 4 had the capacity to understand and make decisions.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/2/2025 at 3:57 p.m. with Resident 2, Resident 2 stated in the smoking patio Resident 3 sat on a wheelchair across her (Resident 2) table and kept asking Resident 2 for a cigarette. Resident 2 stated she (Resident 2) did not have any cigarettes to give and refused to share her (Resident 2) cigarettes. Resident 2 stated Resident 3 grabbed her (Resident 2) by the neck choking her (Resident 2) while sitting and she (Resident 2) fell on her (Resident 2) right side and ended up breaking her headphones. Resident 2 stated that she was shocked and scared at what happened. Resident 2 stated facility staff was not present during the incident. Resident 2 stated Resident 4 witnessed the incident (Resident 3 grabbing Resident 2's neck).</p> <p>During an interview on 6/2/2025 at 4 p.m. with Resident 4, Resident 4 stated on 5/31/2025 around 8 p.m. to 9 p.m., he (Resident 4) saw Resident 3 called Resident 2 a derogatory term and told Resident 2 to give her (Resident 3) a cigarette. Resident 4 stated he observed Resident 3 got up from her wheelchair, jumped on Resident 2, grabbed Resident 2's neck, and Resident 2 fell. Resident 4 stated he observed Resident 3 left the smoking patio after the incident. Resident 4 further stated after witnessing the incident, he (Resident 4) went to the nurses' station to ask for help, but no staff was found.</p> <p>During an interview on 6/3/2025 at 3:20 p.m. with Licensed Vocational Nurse (LVN) 5, LVN 5 stated Certified Nursing Assistant (CNA) 4 reported that Resident 2 was on the floor in the smoking patio. LVN 5 stated that he went to the smoking patio right away and assessed Resident 2. LVN 5 stated Resident 2 complained of five out of 10 pain intensity on the pain scale on her right knee. LVN 5 stated Resident 2 mentioned that Resident 3 pushed her to the floor. LVN 5 stated Resident 2 was upset because her headphones broke and wanted them to be replaced.</p> <p>During an interview on 6/3/2025 at 4:10 p.m. with CNA 4, CNA 4 stated she (CNA 4) was in the hallway pushing another resident (name not indicated) in the wheelchair and heard a noise. CNA 4 stated she (CNA 4) saw Resident 3 rushing back into her room by pushing her (Resident 3) wheelchair. CNA 4 stated she (CNA 4) thought something happened and went right away to the smoking patio. CNA 4 stated she (CNA 4) found Resident 2 lying on the floor in the smoking patio. CNA 4 stated she left the smoking patio and reported the incident to LVN 5.</p> <p>During an interview on 6/4/2025 at 2:17 p.m. with the Administrator, the Administrator stated Resident 3 caused physical harm to Resident 2 and was considered as a physical abuse. The Administrator stated if there was a staff present in the smoking patio, the staff could have made a difference to prevent the incident.</p> <p>During an interview on 6/4/2025 at 2:55 p.m. with the Director of Nursing (DON), the DON stated staff should be present for resident safety if there are residents in the smoking patio.</p> <p>During a review of the facility's policy and procedure titled, Abuse Prevention Program, last reviewed on 1/2025, the policy and procedure indicated, Our residents have the right to be free from abuse This includes but is not limited to . verbal, . physical abuse As part of the resident abuse prevention, the administration will protect our residents from abuse by anyone including, but not necessarily limited to . other residents</p>		

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<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** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a written or electronic record containing all the information the resident needs to effectively manage their own health) for one out of three sampled residents (Resident 1) by failing to ensure Resident 1's care plan was developed and implemented after the physician gave an order for Resident 1 to self-administer medication.</p> <p>This deficient practice had the potential to result in inconsistent implementation of the care plan that may lead to a delay in or lack of delivery of care and services.</p> <p>Findings:</p> <p>During a review of Resident 1's admission Record, the admission Record indicated the facility initially admitted Resident 1 on 11/5/2024 and readmitted on [DATE] with a diagnosis of hypertension (high blood pressure) and chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing).</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 5/9/2025, the MDS indicated Resident 1 had a moderately impaired thought process (difficulty with thinking, learning, and remembering) and required maximal assistance from staff to complete activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily).</p> <p>During a review of Resident 1's Self-Administration of Medication, dated 5/27/2025, the Self-Administration of Medication indicated Resident 1 was fully capable of storing medications in a secure location, capable of opening/closing medication containers, can accurately tell time to know when medications need to be taken, understands that skipping/choosing not to take a medication dose is a refusal of medication and he/she must notify staff when refusal has occurred. The Self-Administration of Medication indicated Resident 1 was fully capable of administering inhalants or inhalers.</p> <p>During a review of Resident 1's Physician Order, dated 5/27/2025, the Physician Order indicated Resident 1 may self-administer inhalers.</p> <p>During a review of Resident 1's care plans, the care plans did not indicate a care plan for Resident 1's self-administration of medication.</p> <p>During a concurrent interview and record review on 6/2/2025 at 12:19 p.m. with the Director of Nursing (DON), Resident 1's care plans were reviewed and did not indicate a care plan for Resident 1's self-administration of medication. The DON stated care plan must be updated to meet Resident 1's physical and psychological functional needs.</p> <p>During a review of the facility policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, last reviewed 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.</p> <p>(continued on next page)</p>		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Self-Administration of Medications, last reviewed 1/2025, the P&P indicated if it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan.		