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	08/14/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to ensure the call light (an alerting device used to contact nursing personnel for assistance) for one of three sampled residents (Resident 1) was accessible and within reach. This failure had the potential to prevent Resident 1 from being able to contact facility staff for help as needed. Findings: During a review of Resident 1's admission Record, dated 8/14/2025, the admission Record indicated Resident 1's diagnoses included lumbar spondylosis (a condition in which the bones and cartilage of the low back are wearing out over time), neuropathy (a condition where nerves in the body are damaged, leading to pain, weakness, and/or difficulty with balance and coordination), and respiratory failure (a condition where the lungs is unable to adequately exchange oxygen and carbon dioxide, leading to dangerously low oxygen levels and/or high carbon dioxide levels in the blood).During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/4/2025, the MDS indicated Resident 1 was dependent for eating, toileting, personal hygiene and with dressing (a helper does all of the effort as the resident is unable to complete the activity).During a review of Resident 1's care plan, dated 7/1/2025, the care plan indicated Resident 1 is at risk for falls. The care plan indicated nursing interventions include ensuring the call light is within reach and [to] encourage the resident to use it for assistance as needed.During an observation on 8/13/2025 at 12:16 p.m. of Resident 1 in her room, Certified Nursing Assistant (CNA 1) was observed inside Resident 1's room near her bed. Resident 1 was sleeping. During a concurrent observation and interview on 8/13/2025 at 12:21 p.m. with CNA 1, CNA 1 stated he was inside Resident 1's room maybe 10 minutes ago. When asked where Resident 1's call light was located, CNA 1 initially looked at Resident 1's bed but could not find the call light. CNA 1 then walked toward the head of the bed where CNA 1 found the call light on the floor behind Resident 1's bed frame. CNA 1 stated it is important to have the call light near the resident for emergencies and in case the resident needs help. During an interview on 8/13/2025 at 12:40 p.m. with Licensed Vocational Nurse (LVN 1), who was the assigned nurse for Resident 1, LVN 1 stated the call light needs to be in reach so if patients need something, they can reach you.During an interview on 8/14/2025 at 3:39 p.m. with Director of Nursing (DON), the DON stated when nursing staff are entering their patient's room to check up on them, the professional standards of practice include the nursing staff checking the position of the patients and if their call light is in reach. The DON stated the consequence of not having the call light within reach is that a resident might fall and cannot contact anybody. The DON stated the call light is important for a resident's overall safety.During a review of the facility's policy and procedure (P&P) titled, Answering the Call Light, revised 9/2022, the P&P indicated the facility must ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. Based on observation, interview, and record review, the facility failed to ensure the respiratory care for one of three sampled residents (Resident 1) was provided in accordance with professional standards of practice and per the doctor's orders, when Resident 1's nasal cannula (a flexible device that delivers extra oxygen through a tube and into the nose) was found inside Resident 1's mouth. This failure had the potential to decrease Resident 1's oxygen levels, leading to respiratory distress (when a person has difficulty breathing because there is not enough oxygen received in the lungs).Findings: During a review of Resident 1's admission Record, dated 8/14/2025, the admission Record indicated Resident 1's diagnoses included congestive heart failure (a condition where the heart cannot pump enough blood to meet the body's needs, which leads to fluid back up in the body especially in the lungs), pleural effusion (when excess fluid builds up between the lung and the chest wall), and respiratory failure (a condition where the lungs is unable to adequately exchange oxygen and carbon dioxide, leading to dangerously low oxygen levels and/or high carbon dioxide levels in the blood).During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/4/2025, the MDS indicated Resident 1 was dependent for eating, toileting, personal hygiene and with dressing (a helper does all of the effort as the resident is unable to complete the activity). During a review of Resident 1's care plan, dated 7/1/2025, the care plan indicated Resident 1 has potential for episodes of [shortness of breath] and requires use of oxygen.continuously via nasal cannula. The care plan indicated Resident 1 is at risk for ineffective breathing pattern, and nursing interventions include administer[ing] oxygen as prescribed. During a review of Resident 1's Order Summary Report, dated 8/1/2025, the Order Summary Report indicated the doctor ordered oxygen at 2 liters per minute (measurement of how much oxygen is being administered) for shortness of breath every shift, which may be increased up to 5 liters if necessary. During an observation on 8/13/2025 at 12:16 p.m. of Resident 1 in her room, Certified Nursing Assistant (CNA 1) was observed inside Resident 1's room near her bed. Resident 1 was sleeping. During a concurrent observation and interview on 8/13/2025 at 12:21 p.m. with CNA 1 inside Resident 1's room, CNA 1 stated he was inside Resident 1's room maybe 10 minutes ago. When asked where Resident 1's oxygen nasal cannula was, CNA 1 pointed to Resident 1's mouth. CNA 1 stated it is important for the nasal cannula to be properly placed in Resident 1's nose so that she gets oxygen. CNA 1 stated that if a CNA finds a nasal cannula out of place, the CNA should notify the charge nurse to address. During an interview on 8/13/2025 at 12:40 p.m. with Licensed Vocational Nurse (LVN 1), LVN 1 stated if a nasal cannula is found inside a resident's mouth, the nurse should first check the resident's oxygen saturation (the amount of oxygen that is circulating in the blood), verify if there is a doctor's order for oxygen, and then replace the nasal cannula. LVN 1 stated the consequence of not having the nasal cannula properly placed inside a resident's nose is the possibility of oxygen desaturation (occurs when blood oxygen levels drop below a normal range). During an interview on 8/14/2025 at 3:39 p.m. with Director of Nursing (DON), the DON stated when nursing staff are entering their residents' rooms to check up on them, the professional standards of practice for respiratory care include the nursing staff checking the position of the residents, if the call light is within reach, and if the nasal cannula has correct placement. The DON stated if a CNA finds a nasal cannula outside of a resident's nose, the CNA should notify the charge nurse who will need to assess the resident. The DON stated the consequence of an improper placement of a nasal cannula is that the resident is deprived of oxygen, which can lead to desaturation. DON stated that if there is a doctor's order for oxygen, then it needs to be followed accordingly. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, revised October 2010, the P&P indicated [o]xygen therapy is administered by way of an oxygen mask, nasal cannula, and/or nasal catheter. The P&P indicated the nasal cannula is a tube that is placed approximately one-half inch into the resident's nose.