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	09/05/2025

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. (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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(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	Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a tool that ensures residents receive personalized, comprehensive, and goal-oriented care in a nursing home setting) for two of four sampled residents (Resident 2 and Resident 3), by failing to develop and implement a care plan for the residents` discharge planning (a process where the facility staff, doctors, the resident and/or the resident's family collaboratively create a plan for after the resident leaves the facility, making sure the resident has the resources needed to stay safe at home or at another facility). This deficient practice had the potential to result in an unreasonable delay with the progress of Resident 2 and Resident 3's plan to be discharged from the facility to a community setting. Findings: 1. During a review of Resident 2's admission Record, dated 9/05/2025, the admission Record indicated the facility admitted the resident on 4/24/2024 with diagnoses including chronic obstructive pulmonary disease (a progressive lung disease that makes it difficult to breathe due to damage to the lungs and airways), type two diabetes mellitus (DM 2-a disorder characterized by difficulty in blood sugar control and poor wound healing), and atrial fibrillation (a condition where the upper chambers of the heart beat irregularly and too fast). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 7/25/2025, the MDS indicated Resident 2 required substantial assistance with toileting hygiene, showering, and dressing the lower body (a helper does more than half the effort in completing the activity). The MDS indicated Resident 2 required clean up assistance with eating and oral hygiene (a helper only sets up or cleans up as the resident completes the activity). During an interview on 8/28/2025 at 10:13 a.m. with Social Services Director (SSD), SSD stated discharge planning starts when residents are first admitted . SSD stated she will ask where [a] resident wants to be discharged , and SSD will determine what outside agency [resources] they might need in preparation for a resident's discharge. During a concurrent interview and record review on 9/5/2025 at 11:25 a.m. with Director of Nursing (DON), Resident 2's care plan dated 9/5/2025 was reviewed. The DON stated social services is responsible for developing a care plan with interventions related to discharge planning. The DON reviewed Resident 2's care plan and could not locate any focus, goal, or intervention related to discharge planning. The DON stated it is important to develop a care plan for discharge planning so that a patient knows where they are going to go, and there is a plan for a safe discharge. The DON stated if the care plan does not include discharge planning, it can be chaos which can cause stress to the patient. 2. During a review of Resident 3's admission Record, dated 9/05/2025, the admission Record indicated the facility admitted the resident on 6/14/2025 with diagnoses including seizures (a sudden burst of electrical activity in the brain that can cause changes in behavior, movements, feelings, and levels of consciousness), hypertension (a condition where the blood pressure is consistently too high), and depression (a mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest in activities that were once enjoyable). During a review of Resident 3's History and Physical Examination (H&P - when a doctor obtains a patient's medical history, performs a physical exam, and documents his/her findings in the patient's medical record), dated 6/15/2025, the H&P indicated Resident 3 had the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 6/17/2025, the MDS indicated Resident 3 required substantial assistance with showering and toileting hygiene (a helper does more than half the effort in completing the activity). The MDS indicated Resident 3 required partial assistance with oral hygiene and upper body dressing (a helper does less than half the effort). The MDS indicated Resident 3 required supervision for eating (a helper provides verbal cues or contact assistance as the resident completes the activity). During a concurrent interview and record review on 9/5/2025 at 11:28 a.m. with DON, Resident 3's care plan dated 9/5/2025 was reviewed. The DON stated social services is responsible for developing a care plan with interventions related to discharge planning. The DON reviewed Resident 3's care plan and could not locate any focus, goal, or intervention related to discharge planning. The DON stated it is important to develop a care plan for discharge planning so that a patient knows where they are going to go, and there is a plan for a safe discharge. The DON stated if the care plan does not include discharge planning, it can be chaos which can cause stress to the patient. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 1/2025, the P&P indicated the following: 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. During a

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards for one of four sampled residents (Resident 1) by failing to document the communications social services had with Resident 1 and the actions taken by social services regarding the resident`s discharge planning. This failure resulted in an incomplete medical record that is not in accordance with the facility's own policies and procedures. Findings:During a review of Resident 1's admission Record, dated 8/14/2025, the admission Record indicated the facility originally admitted the resident on 5/10/2024, and readmitted on [DATE], with diagnoses including chronic obstructive pulmonary disease (a progressive lung disease that makes it difficult to breathe due to damage to the lungs and airways), chronic kidney disease (a condition where the kidneys become damaged and slowly lose the ability to clean waste and fluids from the blood), and major depressive disorder (a mood disorder that causes persistent feelings of sadness and loss of interest and can interfere with daily living). During a review of Resident 1's History and Physical (H&P - when a doctor obtains a patient's medical history, performs a physical exam, and documents his/her findings in the patient's medical record), dated 7/19/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 8/5/2025 the MDS indicated Resident 1 was dependent on toileting hygiene, showering, and dressing the lower body part (a helper does all the effort). The MDS indicated Resident 1 required supervision with eating (a helper provides verbal cues and/or contact guard assistance as the resident completes the activity). During an interview on 9/04/2025 at 1:49 p.m. with Resident 1, Resident 1 stated the last time she spoke with a facility staff member about discharge planning was weeks ago. Resident 1 stated she would like to be transferred to a city closer to their family. Resident 1 stated she (Resident 1) is also willing to discuss any little town near her desired location. During a concurrent interview and record review on 9/5/2025 at 11:25 a.m. with Social Services Director (SSD), Resident 1's electronic medical record was reviewed. SSD stated Resident 1 wants to go up north because of her disabled family member. SSD stated it is important to try to accommodate a resident's discharge planning request because it's for their psychosocial well-being. SSD stated it is important for the residents to feel good about where they are going to stay after being discharged from the facility. SSD stated she has been in communications with a marketer contact for up north, and that SSD explained to Resident 1 that the facilities up north might not be able to accept her because they can't care for her needs. SSD stated she is trying to make sure the possible cities of facilities who can accept Resident 1 are at least going in northern direction. When asked to show documentation of the actions that SSD has taken and the communications SSD has made regarding Resident 1's discharge planning, SSD stated: No, there is no progress note. During a concurrent interview and record review on 9/5/2025 at 11:25 a.m. with Director of Nursing (DON), Resident 1's electronic medical record was reviewed. DON stated it is important to document in a patient's medical record because it is a legal document. DON stated, We document what we do for the patient. DON stated that if there is no documentation in the resident's medical record about discharge planning discussion, then it doesn't exist. DON reviewed Resident 1's electronic medical record and could not locate a notation that discharge planning was discussed between social services and Resident 1. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, dated 1/2025, the P&P indicated [a]ll services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. During a review of the facility's policy and procedure (P&P) titled, Social Services, dated 1/2025, the P&P indicated the director of social services.is responsible for.maintaining records related to social services.