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	12/04/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to provide one of three residents (Resident 1) with the rights for making decisions related to care provided to Resident 1 in his primary understandable language. Resident 1 was discharged from the facility Against Medical Advice (AMA - when a resident leaves a healthcare facility against the advice of their doctor) without receiving discharge instructions related to the risks and benefits associated with leaving the facility AMA in Resident 1's preferred language of Spanish. This deficient practice resulted in the violation of Resident 1's right to be informed in a language the resident understands to weigh the risks and benefits in deciding to leave the facility AMA. Cross reference F627. Findings:During a review of Resident 1's admission Record (AR), the AR indicated the facility originally admitted Resident 1 on 11/9/2022 with diagnoses including alcoholic cirrhosis of the liver with ascites (alcohol-associated liver disease from heavy alcohol drinking causing scarring of the liver and prolonged damage), protein calorie malnutrition (an imbalance of nutrients needed by the body), and alcohol dependence (a disorder characterized by the inability to control consumption of alcohol). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 7/2/2025, indicated Resident 1 was sometimes able to understand others, and was sometimes understood by others. The MDS indicated Resident 1's preferred language is Spanish. During a review of Resident 1's Physician's Order, dated 5/24/2025 at 4:11 p.m., the order indicated allowing Resident 1 to go out on pass (an order to go out of the facility) by himself for no more than 4 hours. During a review of Resident 1's form titled, Leaving Against Medical Advice, dated 9/20/2025, indicated Resident 1 signing the form witnessed by two Registered Nurses (RN 1 & RN 2). During a review of Resident 1's care plan with the focus on Discharge Planning, initiated on 1/10/2025, the care plan indicated Resident 1's goal was to continue in long-term care (provides ongoing medical and non-medical help for people with chronic illnesses or disabilities who cannot manage daily activities alone, supporting independence over extended periods in settings like a nursing home).During a concurrent interview and record review on 12/4/2025 at 3:47 p.m., with Registered Nurse 1 (RN 1), Resident 1's AR, MDS, out on pass physician order, and the form titled, Leaving Against Medical Advice were reviewed. RN 1 stated Resident 1 was self-responsible. RN 1 stated the other Registered Nurse (RN 2), who no longer works for the facility, were both unable to speak or translate in the Spanish language for Resident 1. RN 1 stated Resident 1 was alleged to have a physical abuse with another resident (name not indicated) on 9/20/2025 and Resident 1 was placed on a one-on-one sitter (provides dedicated, constant supervision and support for a single resident). RN 1 stated Resident 1 was upset because he (Resident 1) was placed on one-on-one sitter and Resident 1 verbalized he (Resident 1) wanted to leave the facility on 9/20/2025 at approximately 10 a.m. RN 1 stated Resident 1 said he (Resident 1) was going to a hotel (did not indicate the name of the hotel) with no specific destination. RN 1 stated Resident 1 had an active out-on-pass order. RN 1 stated the failure of the facility was not to provide Resident 1 the instructions in both English and Spanish (AMA form) explaining the risks and benefits associated with leaving the facility AMA.During a review of the facility-provided policy and procedure titled, Resident Rights, with last revised date of 2/2021, indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to g. exercise his or her right as a resident of the facility . h. be supported by the facility in exercising his or her rights; i. exercise his or her rights without interference, coercion, discrimination or reprisal from the facility; j. be informed about his or her rights and responsibilities;During a review of the facility-provided policy and procedure titled, Dignity, with last revised date of 2/2021, indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction in life, and feelings of self-worth and self-esteem. The policy also indicated,3. Individual needs and preferences of the resident are identified though the assessment process.4. Residents may exercise their rights without interference, coercion, discrimination, or reprisal from any person associated with the facility.

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 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 protect the resident's right to be free from physical abuse (deliberately aggressive or violent behavior with the intention to cause harm) for one of seven sampled residents (Resident 2). On 9/20/2025 at 6 a.m., who were both in the hallway had a physical altercation (a confrontation or fight involving physical contact or force) in which Resident 1 hit Resident 2's right side of the head on the door and punched Resident 2 on the left side of the face with a right closed fist. This deficient practice resulted in Resident 2 being subjected to physical abuse by Resident 1 while under the care of the facility. On 9/20/2025, Resident 2 sustained left eye redness and pain level on three (mild pain) out of ten on the numeric pain rating scale (a pain assessment tool that uses a scale ranging from zero [no pain] to ten [worst pain imaginable], to quantify pain intensity). In addition, based on the Reasonable Person Concept (refers to a tool to assist the survey team's assessment of the severity level of negative, or potentially negative, psychosocial outcome the deficiency may have had on a reasonable person in the resident's position), due to Residents 2's impaired cognition (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) and medical condition, an individual subjected to abuse and neglect may have psychological (mental or emotional) effects including feelings of hopelessness (a feeling or state of despair or lack of hope), helplessness (the belief that there is nothing that anyone can do to improve a bad situation), and humiliation (the feeling of being ashamed or losing respect for own self). Findings: During a review of Resident 2's admission Record (undated), the admission Record indicated the facility admitted Resident 2 on 5/17/2024 with diagnoses including encephalopathy (a general disturbance in brain function), major depressive disorder (mental health condition that causes a persistently low or sad mood and a loss of interest in activities that once brought joy), and generalized anxiety disorder (persistent and excessive worry that interferes with daily activities). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 8/7/2025, the MDS indicated Resident 2's cognition was severely impaired. The MDS indicated Resident 2 had little interest or pleasure in doing things for several days. During a review of Resident 2's Change in Condition (COC - when there is a sudden change in a resident's condition) Evaluation, dated 9/20/2025 at 6 a.m., the COC Evaluation indicated Resident 2 received physical abuse from Resident 1 on 9/20/2025 (time not indicated). The COC Evaluation indicated Resident 2 had acute (recent onset) pain on the left face. During a review of Resident 1's admission Record (undated), the admission Record indicated the facility admitted Resident 1 on 11/9/2022 with diagnoses including alcoholic cirrhosis (the destruction of normal liver tissue from years of heavy drinking) with ascites (the build-up of fluid in the abdominal cavity), portal hypertension (high blood pressure in the portal vein), and anxiety disorder. During a review of Resident 1's Physician History and Physical (H&P - comprehensive assessment conducted by a healthcare provider that includes gathering a thorough medical history from the resident and performing a physical examination to assess their overall health and identify any potential medical concern), dated 5/4/2025, the H&P indicated Resident 1 had the capacity to make decisions. During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1's cognition was moderately impaired. During a review of Resident 1's care plan on aggression, initiated on 9/7/2025, the care plan indicated Resident 1 had verbal aggression (any communication intended to harm someone through words, tone, or manner, such as threats, insults, or harsh criticism) and physical aggression (actions that involve inflicting physical harm or damage). The care plan interventions indicated to monitor Resident 1's behavior every shift. During a telephone interview on 9/29/2025 at 3:35 p.m. with Resident 1, Resident 1 stated he (Resident 1) punched Resident 2 on the face. During an interview on 9/30/2025 at 7:07 a.m. with Certified Nursing Assistant (CNA) 5, CNA 5 stated on 9/20/2025 at 6 a.m., she heard Resident 1 shouting and cursing at Resident 2 in the hallway. CNA 5 stated she went towards Resident 1 and Resident 2 when CNA 5 saw Resident 1 stand up and grabbed Resident 2. CNA 5 stated she tried to pull Resident 1 away. During an interview on 9/30/2025 at 7:22 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1 was verbally and physically aggressive to the facility staff and was verbally aggressive to other residents. LVN 1 stated she heard Resident 1 yelling and calling Resident 2 racial slurs. LVN 1 stated she saw Resident 2 walked by Resident 1, who was sitting in a wheelchair in the hallway. LVN 1 stated she saw Resident 1 stand up and pushed Resident 2 against the door. LVN 1 stated Resident 1's left arm was used to pin Resident 2 against the door while his (Resident 1) right hand grabbed Resident 2's head and hit it on the door. LVN 1 stated Resident 1

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

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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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) was provided with discharge instructions in the language (Spanish) preferred by Resident 1 to fully understand the risks and benefits associated with leaving the facility against medical advice (AMA - when a resident leaves a healthcare facility against the advice of their doctor). This deficient practice resulted to Resident 1 being discharged on 9/20/2025 at approximately 10 a.m. without understanding the risks and benefits of leaving the facility AMA. Cross reference F552.Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility originally admitted Resident 1 on 11/9/2022 with diagnoses including alcoholic cirrhosis of the liver with ascites (alcohol-associated liver disease from heavy alcohol drinking causing scarring of the liver and prolonged damage), protein calorie malnutrition (an imbalance of nutrients needed by the body), and alcohol dependence (a disorder characterized by the inability to control consumption of alcohol). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 7/2/2025, indicated Resident 1 was sometimes able to understand others, and was sometimes understood by others. The MDS indicated Resident 1's preferred language is Spanish. During a review of Resident 1's Physician's Order, dated 5/24/2025 at 4:11 p.m., the order indicated allowing Resident 1 to go out on pass (an order to go out of the facility) by himself for no more than 4 hours. During a review of Resident 1's form titled, Leaving Against Medical Advice, dated 9/20/2025, indicated Resident 1 signing the form witnessed by two Registered Nurses (RN 1 & RN 2). During a review of Resident 1's care plan with the focus on Discharge Planning, initiated on 1/10/2025, the care plan indicated Resident 1's goal was to continue in long-term care (provides ongoing medical and non-medical help for people with chronic illnesses or disabilities who cannot manage daily activities alone, supporting independence over extended periods in settings like a nursing home). During a concurrent interview and record review on 12/4/2025 at 3:47 p.m., with Registered Nurse 1 (RN 1), Resident 1's AR, MDS, out on pass physician order, and the form titled, Leaving Against Medical Advice were reviewed. RN 1 stated Resident 1 was self-responsible. RN 1 stated the other Registered Nurse (RN 2), who no longer works for the facility, were both unable to speak or translate in the Spanish language for Resident 1. RN 1 stated Resident 1 was alleged to have a physical abuse with another resident (name not indicated) on 9/20/2025 and Resident 1 was placed on a one-on-one sitter (provides dedicated, constant supervision and support for a single resident). 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These rights include the residents' right to: g. exercise his or her right as a resident of the facility .; h. be supported by the facility in exercising his or her rights; i. exercise his or her rights without interference, coercion, discrimination or reprisal from the facility; j. be informed about his or her rights and responsibilities; During a review of the facility-provided policy and procedure titled, Dignity, with last revised date of 2/2021, the policy and procedure indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction in life, and feelings of self-worth and self-esteem. The policy also indicated, 3. Individual needs and preferences of the resident are identified though the assessment process. 4. Residents may exercise their rights without interference, coercion, discrimination, or reprisal from any person associated with the facility. During a review of the facility-provided policy and procedure titled, Discharging a Resident without a Physician's Approval, with revised date of 1/2025, the policy and procedure indicated, If a resident wishes to be discharged to a setting that does not appear to meet his or her post-discharge needs, or appears unsafe, the facility will treat this situation similarly to refusal of care, and will: a. discuss with the resident . and document the implications and/or risks of being discharged to a location that is not equipped to meet his/her needs and attempt to ascertain why the resident is choosing that location; b. document that other, more suitable, options of locations that are equipped to meet the needs of the resident were presented and discussed; c. document that despite being offered other options that could meet the resident's needs, the