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	04/15/2026

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. Based on interview and record review, the facility failed to develop and implement a person-centered care (CP, a plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs) for one of three sampled residents (Resident 1), by failing to:1. Develop a care plan to address Resident 3's multiple fractures (a partial or complete break, crack, or split in a bone). 2. Develop a care plan to address Resident 3's pain management. These failures had the potential to delay care and negatively affect Resident 3's well-being. Findings: During a review of Resident 3's admission Record, the admission Record indicated the facility admitted Resident 3 on 3/23/2026 with diagnoses including nondisplaced zone II fracture of sacrum (a crack in the upper, triangular bone at the base of the spine [the sacrum]), multiple fractures of ribs left side, displaced fracture of body of scapula (a severe shoulder injury usually caused by trauma), and other fracture of fourth and fifth vertebra (individual, irregular bones that stack together to form the backbone or spinal column). During a review of Resident 3's History and Physical (H&P - a comprehensive assessment of a resident's medical condition), dated 3/24/2026, 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 3/26/2026, the MDS indicated Resident 3 had moderately impaired cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS indicated Resident 3 required moderate assistance (helper does less than half the effort) from facility staff with oral hygiene, toileting hygiene, toilet transfers, showers, and personal hygiene. During a review of Resident 3's Order Summary Report, the report indicated the following physician's order:-3/23/2026: Hydrocodone-Acetaminophen (a combination medication containing an opioid analgesic (hydrocodone) and a non-opioid reliever (acetaminophen) used to treat moderate to severe pain) Oral Tablet 5-325 milligram (mg-unit of measurement). Give two tablets by mouth every for hours as needed for severe pain. During a concurrent interview and record review on 4/15/2026 at 3:21 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 3's Care Plan was reviewed. LVN 1 stated Resident 3's Care Plan did not address Resident 3's fractures and pain management. LVN 1 stated the Care Plan was the guide for the facility staff to move forward with interventions for Resident 3's care. LVN 1 stated the importance of Care Plan was to make sure facility staff were informed of Resident 3's plan of care. LVN 1 stated failure to develop a Care Plan to address Resident 3's pain management and fractures had the potential for the facility staff to make mistakes and delay care for Resident 3. During an interview on 4/15/2026 at 12:40 p.m. with the Director of Nursing (DON), the DON stated the Care Plan should have addressed Resident 3's all existing conditions. The DON stated Resident 3's Care Plan was not comprehensive and had the potential to negatively affect Resident 3's care since Care Plan interventions are used to prevent pain, potential injury, and to maintain Resident 3's safety. During a review of the facility-provided policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, last reviewed on 2/26/2026, 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. 2. The comprehensive, person-centered care plan is developed within seven (7) days of (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 7. The comprehensive, person-centered care plan: . b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. e. reflects currently recognized standards of practice for problem areas and conditions.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the comprehensive care plan (a plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs) was revised for one of three sampled residents (Resident 2), when on 3/16/2026, Resident 2 was transferred to general acute care hospital (GACH) on a 5150 hold (involuntary, 72-hour psychiatric hospitalization for individuals deemed a danger to themselves or others due to mental illness). This deficient practice had the potential to delay provision of care and services for Resident 2.Findings:During a review of Resident 2's admission Record, the admission Record indicted the facility originally admitted Resident 2 on 12/18/2024 and readmitted on [DATE] with diagnoses including schizoaffective disorder (a mental illness that is characterized by disturbances in thoughts affecting mood, and behavior), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), depression (mental health illness causing a persistent feeling of sadness, loss of interest, and can interfere with daily life), and generalized anxiety disorder (feeling of anxiousness that affects daily life). During a review of Resident 2's Minimum Data Set (MDS-a resident assessment tool), dated 3/16/2026, the MDS indicated Resident 2 had moderately impaired cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS indicated Resident 2 was independent with eating, oral hygiene, toileting hygiene, and the ability to walk at least 150 feet (ft-unit of measurement). During a review of Resident 2's Care Plan, created on 3/11/2026, the Care Plan indicated Resident 2 had a behavior problem including aggression, hitting staff, kicking objects, yelling, and cursing. During a review of Resident 2's Progress Note, dated 3/16/2026, the Progress Note indicated that on 3/16/2026 at 2:01 p.m. Resident 2 was transferred to general acute care hospital (GACH) for psychiatric evaluation on a 5150 hold for aggressive behavior towards facility staff and refusing medications. During a review of Resident 2's GACH records, dated 3/16/2026, the GACH records indicated Resident 2 was admitted to GACH on hold for danger to others and gravely disabled (a person who, due to a mental health disorder is unable to provide for their own basic needs). The GACH records indicated that Resident 2 was verbally aggressive, irritable, agitated and with liable mood. The GACH records indicated Resident 2 could not contract for safety, endorsing suicidality as well. During a concurrent interview and record review on 4/14/2026 at 3:21 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 2's Care Plan was reviewed. LVN 1 stated Resident 2's Care Plan did not address Resident 2's transfer to GACH on a 5150 hold and readmission to the facility. During an interview on 4/15/2026 at 12:40 p.m. with the Director of Nursing (DON), the DON stated Resident 2's Care Plan should have addressed Resident 2's readmission to provide new approaches, new interventions to prevent the previous problems to recur. The DON stated it was important to revise Resident 2's Care Plan after readmission in terms of managing residents' behavior. The DON stated failure to revise Resident 2's Care Plan had the potential to negatively affect Resident 2's safety and care. During a review of the facility-provided policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, last reviewed on 2/26/2026, 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. 1. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change. 12. The interdisciplinary team reviews and update the care plan: a. when there has been a significant change in the resident's condition; . c. when the resident has been readmitted to the facility from a hospital stay.

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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 - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free of any significant medication errors (means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order, manufacturer's specifications, and accepted professional standards) for two of three sampled residents (Residents 1 and 3), by failing to ensure:1. Resident 1 received correct dose of Oxycodone Hydrochloride (a strong opioid [a class of powerful drugs used to treat moderate to severe pain by affecting the brain and nervous system] pain medication used to treat moderate to severe pain) for severe pain (seven (7) to 10 out of 10 on the numeric pain rating scale [a pain assessment tool that uses a scale ranging from zero [0 - no pain] to 10 [worst pain imaginable], to quantify pain intensity). 2. Resident 3 received correct dose of Hydrocodone-Acetaminophen (a combination medication containing an opioid analgesic (hydrocodone) and a non-opioid reliever (acetaminophen) used to treat moderate to severe pain) for severe pain. These deficient practices placed Resident 1 and Resident 3 at risk to experiencing unrelieved pain. Findings:a. During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 8/29/2025 with diagnoses including unspecified displaced fracture of fourth cervical vertebra (neck injury where the bone breaks and shifts out of alignment, often requiring stabilization), fracture of nasal bones (a break in the nasal bone or cartilage, often causing deformity, swelling, and pain), and hypertension (high blood pressure). During a review of Resident 1's History and Physical (H&P - a comprehensive assessment of a resident's medical condition), dated 8/30/3036, 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 2/24/2026, the MDS indicated Resident 1's had moderately impaired cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS indicated Resident was dependent (helper does all the effort) on facility staff for toileting hygiene, showers, and lower body dressing. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) from facility staff for personal hygiene. The MDS indicated pain occasionally affected Resident 1's sleep. During a review of Resident 1's Order Summary Report, the report indicated the following physician's order:-8/29/2025: Oxycodone Hydrochloride (a strong opioid [a class of powerful drugs used to treat moderate to severe pain by affecting the brain and nervous system] pain medication used to treat moderate to severe pain) Oral tablet 10 milligram (mg-unit of measurement). Give one (1) tablet by mouth every four (4) hours as needed for severe pain (seven (7) to 10 out of 10 on the numeric pain rating scale . -9/15/20225: Oxycodone Hydrochloride Oral Tablet five (5) mg. Give 1 tablet by mouth every 4 hours as needed for moderate pain (4 to six [6] out of 10 on the numeric pain rating scale). During a concurrent interview and record review on 4/14/2026 at 3:21 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 1's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated March 2026 was reviewed. The MAR indicated, on 3/18/2026, at 6:17 p.m administration time, Resident 1 received 1 tablet of Oxycodone Hydrochloride 5mg for pain level of eight (8) out of 10 on numeric pain rating scale. The MAR indicated, on 3/26/2026, at 6:24 p.m. administration time, Resident 1 received 1 tablet of Oxycodone Hydrochloride 5mg for pain level of eight (8-severe) out of 10 on numeric pain rating scale. The MAR indicated, on 3/30/2026, for 6:11 p.m. administration time, Resident 1 received 1 tablet of Oxycodone Hydrochloride 5mg for pain level of eight (8) out of 10 on numeric pain rating scale. LVN 1 stated the facility staff should have administered 10mg dosage of Oxycodone Hydrocholoride to Resident 1 for severe pain. LVN 1 stated failure to administer correct dose of Oxycodone Hydrochloride was a medication error and had the potential for Resident 1 to experience unrelieved pain. b. During a review of Resident 3's admission Record, the admission Record indicated the facility admitted Resident 3 on 3/23/2026 with diagnoses (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	including nondisplaced zone II fracture of sacrum (a crack in the upper, triangular bone at the base of the spine [the sacrum]), multiple fractures of ribs left side, displaced fracture of body of scapula (a severe shoulder injury usually caused by trauma), and other fracture of fourth and fifth vertebra (individual, irregular bones that stack together to form the backbone or spinal column). During a review of Resident 3's H&P, dated 3/24/2026, the H&P indicated Resident 3 had the capacity to understand and make decisions. During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 had moderately impaired cognitive functioning. The MDS indicated Resident 3 required moderate assistance (helper does less than half the effort) from facility staff with oral hygiene, toileting hygiene, toilet transfers, showers, and personal hygiene. During a review of Resident 3's Order Summary Report, the report indicated the following physician's order:-3/23/2026: Hydrocodone-Acetaminophen (a combination medication containing an opioid analgesic (hydrocodone) and a non-opioid reliever (acetaminophen) used to treat moderate to severe pain) Oral Tablet 5-325 milligram (mg-unit of measurement). Give one tablet by mouth every six (6) hours as needed for moderate pain (four (4) to six (6) out of ten on the numeric pain rating scale. Not to exceed acetaminophen three (3) grams (gm-unit of measurement) in 24 hours from all sources. -3/23/2026: Hydrocodone-Acetaminophen Oral Tablet 5-325 mg. Give two tablets by mouth every four hours as needed for severe pain seven (7) to 10 out of 10 on the numeric pain rating scale. Not to exceed 3gm in 24 hours from all sources.During a concurrent interview and record review on 4/14/2026 at 3:21 p.m. with LVN 1, Resident 3's MAR, dated April 2026 was reviewed. The MAR indicated, on 4/8/2026, at 6:15 a.m. administration time, Resident 3 received 1 tablet of Hydrocodone-Acetaminophen Oral Tablet 5-325 mg for pain level of 10 (severe) out of 10. The MAR indicated, on 4/14/2026, at 6:06 a.m. administration time, Resident 3 received Hydrocodone-Acetaminophen Oral Tablet 5-325 mg for pain level of eight (8-severe) out of 10. LVN 1 stated Hydrocodone-Acetaminophen Oral Tablet 5-325mg 1 tablet was prescribed for moderate pain but was administered to Resident 3 for severe pain. LVN 1 stated the failure to administer 2 tabs of Hydrocodone-Acetaminophen Oral Tablet 5-325mg to Resident 3 for severe pain was a medication error and had the potential for Resident 3 and had the potential to negatively affect Resident 3's mobility, mental health, and decrease Resident 3's livelihood. During an interview on 4/15/2026 at 12:40 p.m. with the Director of Nursing (DON), the DON stated licensed staff should follow physician order, pain scale, and residents' reported pain level to administer pain medications. The DON stated failure to administer pain medications to Resident 1 and Resident 3 as ordered by the physician had the potential for Resident 1 and 3 to experience unrelieved pain. During a review of the facility-provided policy and procedure (P&P) titled, Administering Medications, last reviewed on 2/26/2026, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed. 4. Medications are administered in accordance with prescriber orders, including any required time frame. 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.