

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/07/2026
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)		
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to address the pain level of one of three sampled residents (Resident 1) by failing to follow the physicians' order for pain management for Resident 1. This failure had the potential to place Resident 1 at risk for inadequate pain Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including chronic Kidney disease (progressive loss of kidney function over time), dependent on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), and sepsis (a life-threatening blood infection). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 6/27/2026, the MDS indicated Resident 1 was dependent (helper does all of the efforts) for toileting hygiene, showers, upper/lower body dressing, putting on/taking off footwear and personal hygiene. During a review of Resident 1's History and Physical (H&P-a medical examination that involves a doctor taking a resident's medical history, performing a physical exam, and documenting their findings), dated 6/23/2026, the H&P indicated Resident 1 had capacity to understand and make decisions. During a review of Resident 1's Order Summary Report (OSR), active orders as of 7/07/2026, the OSR indicated, oxycodone hydrochloride (oxycodone HCl - a powerful, semi-synthetic opioid pain medication) oral tablet 5 milligrams (mg- metric unit of measurement) give 5 mg by mouth every 4 hours as needed (PRN) for moderate pain (pain level of 4 to 6 using the pain scale where zero means no pain and 10 as the worst pain) for 14 days, with an order date of 6/22/2026. During a review of Resident 1's Medication Administration Record (MAR), dated 6/2026, the MAR indicated that on 6/24/2026 at 6 a.m. Resident 1 received oxycodone HCl oral tablet 5 mg for pain rated 10 out of 10. The MAR indicated that on 6/26/2026 at 4:34 p.m. Resident 1 received oxycodone HCl oral tablet 5 mg for pain rated 10 out of 10 and at 8:59 p.m. received oxycodone HCl oral tablet for pain rated 9 out of 10. During a concurrent interview and record review on 7/07/2026 at 10:14 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 1's MARs dated 6/1/2026 to 6/30/2026 were reviewed. LVN 1 stated that staff administered oxycodone 5 mg for pain levels of 9 out of 10 and 10 out of 10 despite the physician order indicating administration to moderate pain (pain level 4-6). LVN 1 stated that the nursing staff should have contacted the physician to clarify the order or obtain a new physician order to address Resident 1's reported pain level of 10 out of 10. During a concurrent interview and record review on 7/07/2026 at 12:19 p.m. with Quality Assurance (QA) nurse, Resident 1's MAR was reviewed. QA nurse stated that nursing staff should have contacted Resident 1's physician to obtain a PRN order for severe pain (pain level of 7 to 10) when Resident 1 reported a pain level 10 out of 10. QA nurse stated that nursing staff did not follow the physicians' order because they administered medication indicating moderate pain to treat severe pain. QA nurse stated that the oxycodone 5 mg likely did not adequately control Resident 1's severe pain because the (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 555132 If continuation sheet Page 1 of 4

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident required a higher level of pain management. During a review of the facility's policy and procedures (P&P) titled, Pain Assessment and Management, revised on 3/2020, the P&P indicated 5. Implement the medication regimen as ordered, carefully documenting the results of the intervention. During a review of the facility's P&P titled, Administering Medications, revised on 4/2019, the P&P indicated 4. Medication are administered in accordance with prescriber orders.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain medication cart 2 clean and store medications for one of three sampled resident (Resident 1) when Resident 1's medications were not stored separately after Resident 1 was transferred to the General Acute Care Hospital (GACH) on 6/27/2026. This failure had the potential to result in improper medication storage of Resident 1's medications which can lead to medication errors and potential harm to other residents. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including chronic Kidney disease (progressive loss of kidney function over time), dependent on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), and sepsis (a life-threatening blood infection). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 6/27/2026, the MDS indicated Resident 1 was dependent (helper does all of the efforts) for toileting hygiene, showers, upper/lower body dressing, putting on/taking off footwear and personal hygiene. During a review of Resident 1's History and Physical (H&P-a medical examination that involves a doctor taking a resident's medical history, performing a physical exam, and documenting their findings), dated 6/23/2026, the H&P indicated Resident 1 had capacity to understand and make decisions. During a concurrent observation and interview on 7/06/2026 at 3:30 p.m. with Licensed Vocational Nurse (LVN) 3, in station 1, observed the following inside the medication cart 2: -Found left bottom drawer with medication spills and the bottles of medication sticky; container of sanitizer wipes was mixed with the medications. -Found right bottom drawer with Resident 1's Eliquis (blood thinner) 5 milligrams (mg- metric unit of measurement) tablet, fludrocortisone (prescription steroid medication) 0.1 mg tablet, and Midodrine (used to treat low blood pressure) HCL 10 mg tablet; container of sanitizer was mixed with the medications. LVN 3 stated that nursing staff are responsible for maintaining medication cart 2 in a clean and organized condition. LVN 3 stated that staff stored Resident 1's medication in the bottom right drawer of medication cart 2 while Resident 1 was transferred to GACH. LVN 2 stated that staff should not store sanitizer wipes with medications and should kept them separated. During interview on 7/07/2026 at 12:19 p.m. with the Quality Assurance (QA) nurse, the QA nurse stated that nursing staff are responsible for keeping medication carts clean organized. QA nurse stated that staff should remove medications from the medication cart when Resident 1 was transferred to GACH so they will not be mixed with other medications and for residents safety. The QA nurse further stated that staff should not store medications next to sanitizing wipes. During a review of the facility's policy and procedures (P&P) titled, Storage of Medications, revised on 11/2020, the P&P indicated, The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure accurate medical records when nursing staff failed to accurately document Resident 1's location of pain at the time of Oxycodone (a powerful, semi-synthetic opioid pain medication) administration for one of three sampled residents (Resident 1). This failure had the potential to result in inaccurate clinical documentation, ineffective pain management and compromised continuity of care for Resident 1. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including chronic Kidney disease (progressive loss of kidney function over time), dependent on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), and sepsis (a life-threatening blood infection). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 6/27/2026, the MDS indicated Resident 1 was dependent (helper does all of the efforts) for toileting hygiene, showers, upper/lower body dressing, putting on/taking off footwear and personal hygiene. During a review of Resident 1's History and Physical (H&P-a medical examination that involves a doctor taking a resident's medical history, performing a physical exam, and documenting their findings), dated 6/23/2026, the H&P indicated Resident 1 had capacity to understand and make decisions. During a concurrent interview and record review on 7/07/2026 at 11:43 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 1's Administration Notes were reviewed. LVN 2 stated that nursing staff did not document the location of Resident 1's pain in the medical record. LVN 2 stated that nursing staff should document the specific body site affected by pain to allow staff to assess the administered medication effectively treated Resident 1's pain. During a concurrent interview and record review on 7/07/2026 at 12:19 p.m. with Quality Assurance (QA) nurse, Resident 1's Medication Administration Record (MAR) and Administration notes were reviewed. QA nurse stated that nursing staff did not accurately document the location of pain for Resident 1 when administering Oxycodone. QA nurse stated that nursing staff should document the specific location of the resident's pain in detail to assess effectiveness in relieving pain at the documented site. During a review of the facility's policy and procedure (P&P) titled, Pain Assessment and Management, revised 3/2020, the P&P indicated, Document the resident's reported level of pain with adequate detail (i.e., enough information to gauge the status of pain and the effectiveness of interventions of pain) as necessary and in accordance with the pain management program. Upon completion of the pain assessment, the person conducting the assessment shall record the information obtained from the assessment in the resident's medication record.		