

# Department of SOCIAL SERVICES

Community Care Licensing

## COMPLAINT INVESTIGATION REPORT

Facility Number: 197609969  
Report Date: 06/30/2025  
Date Signed: 06/30/2025 07:00:42 PM

**Substantiated**

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION WOODLAND HILLS N.ASC, 21731 VENTURA BLVD. #250 WOODLAND HILLS, CA 91364
<b>COMPLAINT INVESTIGATION REPORT</b>	

This is an official report of an unannounced visit/investigation of a complaint received in our office on **05/16/2024** and conducted by Evaluator Christine Yee

<b>PUBLIC</b>	<b>COMPLAINT CONTROL NUMBER: 29-AS-20240516080757</b>
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<b>FACILITY NAME:</b> VALLEY VISTA SENIOR LIVING	<b>FACILITY NUMBER:</b> 197609969
<b>ADMINISTRATOR:</b> ELIZABETH J WHITTINGTON	<b>FACILITY TYPE:</b> 740
<b>ADDRESS:</b> 7040 VAN NUYS BLVD	<b>TELEPHONE:</b> (818) 906-4400
<b>CITY:</b> VAN NUYS	<b>STATE:</b> CA
<b>CAPACITY:</b> 164	<b>ZIP CODE:</b> 91405
	<b>CENSUS:</b> 77
	<b>DATE:</b> 06/30/2025
	<b>UNANNOUNCED TIME BEGAN:</b> 10:28 AM
<b>MET WITH:</b> Elizabeth Whittington, Executive Director	<b>TIME COMPLETED:</b> 07:10 PM

**ALLEGATION(S):**

1	1. Facility did not provide resident with a bed/dresser
2	2. Facility did not provide resident with hygiene products
3	
4	
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6	
7	
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9	

**INVESTIGATION FINDINGS:**

1	Licensing Program Analyst (LPA) Christine Yee conducted another subsequent unannounced complaint
2	visit to continue the investigation for the above allegations and to deliver the findings of the investigation.
3	LPA met with Elizabeth Whittington, Executive Director. The reason for today's visit was provided.
4	
5	On the initial visit conducted on 5/22/24, LPA Yee conducted an interview with Maria Calderon at
6	11:41am, Jarred Massey-Baker, Memory Care Director at 12:07pm, Staff #1 at 1:23pm, Staff #2 at
7	1:50pm, telephone interview with Witness #1 at 2:04pm and the Administrator at 2:56pm. Resident #1's
8	file was reviewed at 2:28pm and copies requested. Based on the information received during the initial
9	visit, further investigation was needed to make a finding for the above allegations. Exit interview was
10	conducted.
11	
12	A subsequent unannounced complaint visit was conducted on 6/19/25 to continue the investigation of the
13	above allegations and LPA met with Elizabeth Whittington, Executive Director. On the subsequent visit

**Substantiated**

**Estimated Days of Completion:**

**NAME OF LICENSING PROGRAM MANAGER:** Kristin Heffernan

**NAME OF LICENSING PROGRAM ANALYST:** Christine Yee

**LICENSING PROGRAM ANALYST SIGNATURE:**

**DATE:** 06/30/2025

I acknowledge receipt of this form and understand my licensing appeal rights as explained and received.

**FACILITY REPRESENTATIVE SIGNATURE:**

**DATE:** 06/30/2025

This report must be available at Child Care and Group Home facilities for public review for 3 years.

LIC9099 (FAS) - (06/04)

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**Control Number** 29-AS-20240516080757

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES  
COMMUNITY CARE LICENSING DIVISION  
WOODLAND HILLS N.ASC, 21731 VENTURA BLVD. #250  
WOODLAND HILLS, CA 91364

## COMPLAINT INVESTIGATION REPORT (Cont)

**FACILITY NAME:** VALLEY VISTA SENIOR LIVING

**FACILITY NUMBER:** 197609969

**VISIT DATE:** 06/30/2025

### NARRATIVE

1 Page 2

2

3 LPA Yee reviewed and collected additional documents related to the investigation throughout the visit  
4 and conducted additional interviews with the Executive Director at 1:31pm, attempted to conduct  
5 telephone interviews with Staff #3 and Staff #4. Staff #3 returned LPA Yee's call at 3:51pm and began  
6 the telephone interview and the call was disconnected at 4:03pm. When LPA Yee called back at 4:04pm,  
7 she was informed by Staff #3 that the phone interview was being conducted on personal time and to  
8 conduct the interview during working hours. Staff #4 was contacted at 4:07pm and LPA Yee left a voice  
9 mail message to return the call. No return call was received when the subsequent visit was concluded.  
10 Hygiene products and toilet paper were observed in a large closet located on the second floor at  
11 5:45pm. Additional hygiene products are also stored in a smaller closet on the third floor and toilet paper  
12 is located in the housekeeping closets on each floor. Based on the information received on today's visit  
13 and the need to conduct interviews with Staff #3 and Staff #4, it was determined that further  
14 investigation is needed before a determination could be made for the above allegations. An exit  
15 interview was conducted and a copy of this report was provided.

16

17 On today's visit LPA Yee conducted an interview with Staff #5 at 10:49am, Staff #6 at 11:34am and  
18 another telephone interview with Witness #1 at 11:23am to obtain additional information regarding  
19 facility furniture and hygiene products.

20

21 Per the investigation conducted, the following was revealed regarding allegation #1-facility did not  
22 provide resident with a bed/dresser, the staff are confused about who provides the furniture for the  
23 residents' use. Staff all indicated that the residents bring in their own furniture. Per interview conducted  
24 with Maria Calderon, Wellness Director at the time of Resident #1's admission, she stated that the family  
25 of the resident provides the furniture for the residents' use. Per interview conducted with Witness #1,  
26 they were told to purchase a bed and a dresser by Elizabeth Whittington, Sales Manager \*\*\*\*\*who was  
27 making the arrangements for Resident #1's move in on 9/22/23. Per Witness #1, Elizabeth Whittington,  
28 told them that the facility does not provide a bed, a dresser, a phone and hygiene products. She  
29 provided the family with a link to Apria, where the facility buys their health supplies. Per Witness #1, they  
30 didn't know that the furniture had to be delivered first before Resident #1 could move in. Per Witness #1,  
31 Resident #1 was taken back to the Emergency Room until the furniture could be delivered. Resident #1  
32 did not move in until 9/29/23. Also, per review of the signed Admission Agreement - #5 j) "Furnishing"  
under "Accommodations and Basic

**NAME OF LICENSING PROGRAM MANAGER:** Kristin Heffernan

**NAME OF LICENSING PROGRAM ANALYST:** Christine Yee

**LICENSING PROGRAM ANALYST SIGNATURE:**

**DATE:** 06/30/2025

I acknowledge receipt of this form and understand my licensing appeal rights as explained and received.

**FACILITY REPRESENTATIVE SIGNATURE:**

**DATE:** 06/30/2025

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION WOODLAND HILLS N.ASC, 21731 VENTURA BLVD. #250 WOODLAND HILLS, CA 91364
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**COMPLAINT INVESTIGATION REPORT (Cont)**

**FACILITY NAME:** VALLEY VISTA SENIOR LIVING      **FACILITY NUMBER:** 197609969  
**VISIT DATE:** 06/30/2025

NARRATIVE	
1	Page 3
2	
3	Services" the facility states that "If the resident is unable to provide Resident's own furniture or if the
4	resident chooses not to provide it, the Community will ensure that the resident is provided with the basic
5	furniture." This did not happen. The facility did not provide Resident #1 with a bed and dresser as stated
6	in the Admission Agreement and delayed the resident's move-in date to 9/29/23. Per the initial interview
7	conducted with Executive Director on 5/22/24, LPA Yee was specifically told that they had beds and
8	lamps that the family can rent or loan. In the subsequent interview conducted on 6/19/25, the Executive
9	Director denies that she told the family that they had to buy a bed and a dresser. Based on the
10	interviews conducted with staff, there is confusion as to who provides the required Title 22 furniture.
11	Staff all indicated that the resident's families provide the required furniture. Per the information received
12	during the investigation, there is sufficient evidence to support the allegation that the facility did not
13	provide resident with a bed and a dresser, therefore the allegation is deemed substantiated at this time.
14	
15	The investigation into allegation #2 - Facility did not provide resident with hygiene products, revealed
16	that the facility does not provide hygiene products to the residents on an ongoing basis. Per interviews
17	conducted with staff, Residents' families are required to bring in hygiene products such as body soap,
18	shampoo, lotions, toothbrushes and toothpaste for the residents' use. When the hygiene products run
19	low, the manager contacts the family to replenish the hygiene products. Per staff, the facility will provide
20	temporary hygiene products for residents' use if they have extras or until the family is able to bring the
21	hygiene products. Per review of the Admission Agreement under #2 "Fees" letter e) Personal Supplies:
22	The Community assumes that the resident will provide their own supplies for personal care and hygiene.
23	The Admission Agreement does not make provisions to ensure that residents who are unable or choose
24	not to provide their own hygiene products, with hygiene items of general use such as soap and toilet
25	paper. Based on the information obtained during the investigation, there is sufficient evidence to support
26	the allegation that the facility does not provide residents with hygiene products, therefore the allegation
27	is deemed substantiated at this time.
28	
29	Deficiencies are cited under California Code of Regulations, Title 22, Division 6, Chapter 8.
30	
31	Exit interview was conducted, Appeals Rights were discussed and a copy was provided.
32	

**NAME OF LICENSING PROGRAM MANAGER:** Kristin Heffernan  
**NAME OF LICENSING PROGRAM ANALYST:** Christine Yee  
**LICENSING PROGRAM ANALYST SIGNATURE:** \_\_\_\_\_ **DATE:** 06/30/2025

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**FACILITY REPRESENTATIVE SIGNATURE:** \_\_\_\_\_ **DATE:** 06/30/2025

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**ADMINISTRATOR:** ELIZABETH J WHITTINGTON      **FACILITY TYPE:** 740  
**ADDRESS:** 7040 VAN NUYS BLVD      **TELEPHONE:** (818) 906-4400

CITY: VAN NUYS STATE: CA ZIP CODE: 91405  
 CAPACITY: 164 CENSUS: 77 DATE: 06/30/2025  
 UNANNOUNCED TIME BEGAN: 10:28 AM  
 MET WITH: Elizabeth Whittington, Executive Director TIME COMPLETED: 07:10 PM

**ALLEGATION(S):**

1	3. Staff stole residents necklace
2	4. Staff stole residents perfume
3	5. Staff did not clean residents room
4	6. Due to lack of supervision, resident had multiple falls resulting in injury
5	7. Staff did not wash residents hair properly
6	
7	
8	
9	

**INVESTIGATION FINDINGS:**

1	Licensing Program Analyst (LPA) Christine Yee conducted another subsequent unannounced complaint
2	visit to continue the investigation for the above allegations and to deliver the findings of the investigation.
3	LPA met with Elizabeth Whittington, Executive Director. The reason for today's visit was provided.
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5	On the initial visit conducted on 5/22/24, LPA Yee conducted an interview with Maria Calderon at
6	11:41am, Jarred Massey-Baker, Memory Care Director at 12:07pm, Staff #1 at 1:23pm, Staff #2 at
7	1:50pm, telephone interview with Witness #1 at 2:04pm and the Administrator at 2:56pm. Resident #1's
8	file was reviewed at 2:28pm and copies requested. Based on the information received during the initial
9	visit, further investigation was needed to make a finding for the above allegations. Exit interview was
10	conducted.
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12	A subsequent unannounced complaint visit was conducted on 6/19/25 to continue the investigation of the
13	above allegations and LPA met with Elizabeth Whittington, Executive Director. On the subsequent visit

<b>Unsubstantiated</b>	<b>Estimated Days of Completion:</b>
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**NAME OF LICENSING PROGRAM MANAGER:** Kristin Heffernan  
**NAME OF LICENSING PROGRAM ANALYST:** Christine Yee  
**LICENSING PROGRAM ANALYST SIGNATURE:** \_\_\_\_\_ **DATE:** 06/30/2025

I acknowledge receipt of this form and understand my licensing appeal rights as explained and received.

**FACILITY REPRESENTATIVE SIGNATURE:** \_\_\_\_\_ **DATE:** 06/30/2025

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 LIC9099 (FAS) - (06/04) Page: 4 of 9  
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STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY  <b>COMPLAINT INVESTIGATION REPORT (Cont)</b>	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION WOODLAND HILLS N.ASC, 21731 VENTURA BLVD. #250 WOODLAND HILLS, CA 91364
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**FACILITY NAME:** VALLEY VISTA SENIOR LIVING **FACILITY NUMBER:** 197609969  
**VISIT DATE:** 06/30/2025

**NARRATIVE**

1	Page 2A
2	
3	LPA Yee reviewed and collected additional documents related to the investigation throughout the visit
4	and conducted additional interviews with the Executive Director at 1:31pm, attempted to conduct
5	telephone interviews with Staff #3 and Staff #4. Staff #3 returned LPA Yee's call at 3:51pm and began
6	the telephone interview and the call was disconnected at 4:03pm. When LPA Yee called back at 4:04pm,
7	she was informed by Staff #3 that the phone interview was being conducted on personal time and to
8	conduct the interview during working hours. Staff #4 was contacted at 4:07pm and LPA Yee left a voice
9	mail message to return the call. No return call was received when the subsequent visit was concluded.
10	Hygiene products and toilet paper were observed in a large closet located on the second floor at
11	5:45pm. Additional hygiene products are also stored in a smaller closet on the third floor and toilet paper
12	is located in the housekeeping closets on each floor. Based on the information received on today's visit
13	and the need to conduct interviews with Staff #3 and Staff #4, it was determined that further
14	investigation is needed before a determination could be made for the above allegations. An exit

15 interview was conducted and a copy of this report was provided.

16  
17 On today's visit LPA Yee conducted an interview with Staff #5 at 10:49am, Staff #6 at 11:34am and  
18 another telephone interview with Witness #1 at 11:23am to obtain additional information regarding  
19 facility furniture and hygiene products.

20  
21 The investigation regarding Allegation #3 – staff stole the resident's necklace, interviews and file review,  
22 reveal that Resident #1 and the facility did not complete an LIC621 "Client/Resident Personal Property  
23 and Valuables." Per interviews conducted, no one observed Resident #1 with a gold chain and a gold  
24 cross. There is also no documentation that Resident #1 owned a gold chain with a gold cross and that it  
25 was brought into the facility. Staff who were interviewed stated that they observed Resident #1 with a  
26 rope chain that was tarnished with a cross that had rhinestones. Resident #1 was wearing it when they  
27 moved from the facility. Another Staff stated that they saw the resident wearing a thick chunky silver  
28 chain that was tarnished and does not remember if it had a cross or any pendant. Resident #1 also wore  
29 a bracelet. Resident #1 would take off the necklace and then put it back on. Per Staff interviewed, the  
30 jewelry were not of any value that someone would want to steal it or mind if it got lost. Per Staff #4, they  
31 had a great rapport  
32

**NAME OF LICENSING PROGRAM MANAGER:** Kristin Heffernan

**NAME OF LICENSING PROGRAM ANALYST:** Christine Yee

**LICENSING PROGRAM ANALYST SIGNATURE:**

**DATE:** 06/30/2025

**I acknowledge receipt of this form and understand my licensing appeal rights as explained and received.**

**FACILITY REPRESENTATIVE SIGNATURE:**

**DATE:** 06/30/2025

LIC9099 (FAS) - (06/04)

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STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

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WOODLAND HILLS, CA 91364

## COMPLAINT INVESTIGATION REPORT (Cont)

**FACILITY NAME:** VALLEY VISTA SENIOR LIVING

**FACILITY NUMBER:** 197609969

**VISIT DATE:** 06/30/2025

### NARRATIVE

1 Page 3A

2  
3 with the family and spoke daily and yet the family never mentioned anything about the missing chain.  
4 Per the Memory Care Director, they looked for the necklace when the family brought up the missing  
5 necklace and was not able to locate the necklace matching the During the investigation, LPA was not  
6 able to locate anyone who observed Resident #1 wearing a gold chain with a gold cross or anyone to  
7 establish the existence of the gold necklace. Unless new information surfaces, there is insufficient  
8 evidence at this time to support the allegation that the staff stole the residents necklace, therefore, the  
9 allegation is unsubstantiated at this time.

10  
11 Per LPA Yee's investigation in regards to Allegation #4 - staff stole residents perfume, the investigation  
12 revealed that staff observed that Resident #1 had many perfumes and loved perfumes. The mini bottles  
13 of perfumes were stored in a glass vanity drawer. The resident would take all the perfumes out of the  
14 drawer just to decide which perfume was going to be used and then put them all back. If the resident  
15 had anything of value, the perfumes would be it. Per interview with staff, the number of perfumes owned  
16 by Resident #1 varied. One staff indicated that the resident owned 7-8 mini bottles of perfume, one staff  
17 indicated that the resident had 2-3 medium bottles of perfume and another just indicated the resident  
18 had many but never saw anyone using them. Per staff, the perfumes were packed up when resident #1  
19 relocated to another home on 1/15/24. Staff are surprised that the family are now bringing up all these  
20 missing items months later. Per staff, they don't know what happened to the perfumes. The family never  
21 said anything when Resident #1 lived here. Based on the investigation, LPA Yee was not able find  
22 sufficient evidence to support the allegation that staff stole the residents perfumes, therefore the  
23 allegation is unsubstantiated at this time.  
24

25  
26 The investigation into Allegation #5 - Staff did not clean residents room, the resident's family alleges that  
27 they dropped a plant on the floor and the dirt fell out. Staff left the dirt on the floor for weeks and staff did  
28 not clean it up. Per interview conducted with Staff #1, who is assigned to the Memory Care Unit,  
29 Resident #1 had a tiny plant on the window. Resident #1 loved to throw the plant. They would pick up  
the dirt and put it back in the pot. Resident #1 threw the plant because resident would get anxious when

30 family member left. Per Staff #1, Resident #1's room is cleaned every Wednesday and the common  
31 areas are cleaned everyday. There is no dirt left on the floor. Staff #1 works from Tuesday - Saturday  
32 and if the floor is dirty, staff will tell her. On the days Staff #1 is off and there is an emergency another  
staff will clean up. The floor is never left dirty. Other staff interviewed also confirm that the floor is never  
left dirty for days. Managers do room checks and staff will hear about it. Per the investigation, there is  
insufficient evidence to support the allegation that

**NAME OF LICENSING PROGRAM MANAGER:** Kristin Heffernan

**NAME OF LICENSING PROGRAM ANALYST:** Christine Yee

**LICENSING PROGRAM ANALYST SIGNATURE:**

**DATE:** 06/30/2025

**I acknowledge receipt of this form and understand my licensing appeal rights as explained and received.**

**FACILITY REPRESENTATIVE SIGNATURE:**

**DATE:** 06/30/2025

LIC9099 (FAS) - (06/04)

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**Control Number** 29-AS-20240516080757

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## COMPLAINT INVESTIGATION REPORT (Cont)

**FACILITY NAME:** VALLEY VISTA SENIOR LIVING

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**VISIT DATE:** 06/30/2025

### NARRATIVE

1 Page 4A

2

3 staff did not clean the resident's room, therefore the allegation is deemed unsubstantiated at this time.

4

5 Per information received during the investigation for Allegation #6 - Due to lack of supervision, resident  
6 had multiple falls resulting in injury, the investigation revealed that Resident #1, who is diagnosed with  
7 dementia and is placed in the Memory Care located on third floor. The third floor is fire cleared for  
8 delayed egress. She uses a walker to assist in ambulating. Per review of the staff schedule, the staff in  
9 Memory Care consists of a Medication Technician and 2 caregivers for the morning and evening shift  
10 and a Medication Technician and a caregiver in Memory Care and one in Assisted Living on the NOC  
11 shift. Per information, provided, Resident #1 is able to move around freely in their room and in the the  
12 common areas. Per interviews with staff, Resident #1 is very aggressive with their walker and is told to  
13 slow down or to be careful in the use of the walker. The staff do not restrict Resident #1's movement and  
14 do not follow the resident around and falls are expected since the facility does not provide one on one  
15 supervision to catch the resident each time they fall. Per review of hospital discharge documents  
16 obtained, Resident #1 has had 3 un-witnessed falls and one witnessed fall in the dining room. The  
17 resident had their first fall on 10/16/23 in the dining room. Resident did not sustain any injury and was  
18 not sent to the hospital at the request of family. The second fall was sustained on 12/10/23 and 911 was  
19 called and the resident was transported to the hospital to be assessed. CT scans were done on the  
20 head and cervical spine. There were no signs of fracture. Resident sustained a scalp hematoma that  
21 was treated and was discharged. The third fall was sustained on 12/17/23. A CT scan was done on the  
22 facial bones and no fracture was observed. A fourth fall was sustained on 1/1/24. CT scans were done  
23 on the cervical spine and brain, chest x-rays and right elbow x-rays were done. CT scans and x-rays  
24 were ordered and came back okay related to the fall. Resident had a frontal scalp swelling. The resident  
25 was placed on 24 hour monitoring upon return. Per the investigation, the falls are not due to lack of  
26 supervision, the resident has the right to move around and do activities without interference from staff.  
27 Staff are present to ensure the resident's safety and to obtain medical attention when the resident falls.  
28 Based on the investigation, there is insufficient evidence to support the allegation that due to lack of  
29 supervision, resident had multiple falls, resulting in injury, therefore the allegation is unsubstantiated at  
30 this time.

31

32

**NAME OF LICENSING PROGRAM MANAGER:** Kristin Heffernan

**NAME OF LICENSING PROGRAM ANALYST:** Christine Yee

**LICENSING PROGRAM ANALYST SIGNATURE:**

**DATE:** 06/30/2025

**I acknowledge receipt of this form and understand my licensing appeal rights as explained and received.**

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LIC9099 (FAS) - (06/04)

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**FACILITY NAME:** VALLEY VISTA SENIOR LIVING

**FACILITY NUMBER:** 197609969

**VISIT DATE:** 06/30/2025

**NARRATIVE**

1	Per investigation into Allegation #7 - Staff did not wash residents hair properly, the investigation revealed
2	that Resident #1's hair is washed when they are showered. The resident is showered 2 times a week.
3	Per information received from interviews, when the resident first moved in, they would not let the
4	caregivers give them a shower, wash and comb their hair. The resident's hair would be matted because
5	they were taking care of their own hair. Per the caregivers interviewed, once Resident #1 finally got
6	comfortable with them, they would allow them to wash the resident's hair and add conditioner to take out
7	the tangles. They would comb Resident #1's hair and put it in a pony tail everyday. Resident #1's hair
8	was never in a dreadlock as alleged by family. Resident #1 is a very clean person and would bring a
9	comb or brush to find Staff #3 or Staff #4 to comb their hair. Per Staff #3 and Staff #4, they also have
10	African American hair and they know how to care for Resident #1's hair. They also put lotion on Resident
11	#1 after a shower or if they observed their skin to be dry. Per staff, Resident #1 always smelled of lotion.
12	Per interview with family, the facility has an outside hair contractor who refused to do hair grooming for
13	Resident #1 because they were unfamiliar with African American hair. Based on the investigation, there
14	is insufficient evidence to support the allegation that the staff did not wash residents hair properly,
15	therefore the allegation is unsubstantiated at this time.
16	
17	Deficiencies were cited under California Code of Regulations, Title 22, Division 6, Chapter 8
18	
19	Exit interview was conducted, Appeals Rights were discussed and a copy was given.
20	
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**NAME OF LICENSING PROGRAM MANAGER:** Kristin Heffernan  
**NAME OF LICENSING PROGRAM ANALYST:** Christine Yee  
**LICENSING PROGRAM ANALYST SIGNATURE:** **DATE:** 06/30/2025

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LIC9099 (FAS) - (06/04)

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**FACILITY NUMBER:** 197609969

**DEFICIENCY INFORMATION FOR THIS PAGE:**

**VISIT DATE:** 06/30/2025

Deficiency Type POC Due Date /	DEFICIENCIES	PLAN OF CORRECTIONS(POCs)
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Section Number		
Type B 07/07/2025 <b>Section Cited</b> CCR 87307(a)(3)(A-B)	1 Personal Accommodations and 2 Services:The following provisions shall 3 apply-Equipment and supplies 4 necessary for personal care and 5 maintenance of adequate hygiene 6 practice shall be readily available to 7 each resident. A bed for each resident, 8 except that married couples may	1 The Licensee will ensure that a resident 2 is provided with a bed, chair, lamp, 3 night stand and a closet if they are 4 unable or choose not to provide them. 5 Licensee will review Title 22 Section 6 87307 - Personal Accommodations and 7 Services and submit a written 8 statement that the section was read, 9 understood and will be
	8 be provided with one appropriate sized 9 bed. B) Bedroom furniture, which shall 10 include, for each resident, a chair, night 11 stand, a lamp, or lights sufficient for 12 reading, and a chest of drawers. A bed 13 and a dresser was not provided for 14 Resident #1's use	8 adhered to at all times by 7/7/25. 9 10 11 12 13 14
Type B 07/07/2025 <b>Section Cited</b> CCR 87307(a)(3)(D)	1 Personal Accommodations and 2 Services:The following provisions shall 3 apply-Equipment and supplies 4 necessary for personal care and 5 maintenance of adequate hygiene 6 practice shall be readily available to 7 each resident....if the resident is unable 8 or chooses not to provide them,	1 The licensee will review and update the 2 Admission Agreement to include 3 provisions of personal hygiene supplies 4 if the resident is unable to or chooses 5 not to provide personal hygiene 6 supplies and how the facility will make 7 available hygiene items available for 8 the residents' 9 residents.
	8 the licensee shall assure provision of D) 9 Hygiene items of general use such as 10 soap and toilet paper. 11 12 13 14	8 use. Licensee will also educate the staff 9 so that they are aware that hygiene 10 products will be provided by the facility if 11 the resident chooses not to provide 12 them. Provide a copy of the revised 13 Admission Agreement related to 14 Personal Hygiene by 7/7/25

**Failure to correct the cited deficiency(ies), on or before the Plan of Correction (POC) due date, may result in a civil penalty assessment.**

<b>NAME OF LICENSING PROGRAM MANAGER:</b> Kristin Heffernan <b>NAME OF LICENSING PROGRAM ANALYST:</b> Christine Yee <b>LICENSING PROGRAM ANALYST SIGNATURE:</b>		<b>DATE:</b> 06/30/2025
<b>I acknowledge receipt of this form and understand my appeal rights as explained and received.</b>		
<b>FACILITY REPRESENTATIVE SIGNATURE:</b>		<b>DATE:</b> 06/30/2025