STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055287	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Palms Care Center	13400 Sherman Way N Hollywood, CA 91605

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 43418 Based on interview and record review, the facility failed to provide an environment that is free from accidents when one of three sampled residents (Resident 1) was not accurately evaluated for fall risk when Resident 1 ' s Fall Risk Assessment, dated 4/11/2024, indicated Resident 1 was not at risk for falls. This deficient practice had the potential for the facility to not develop and implement a plan of care to prevent falls and injuries in residents. Findings: A review of Resident 1 ' s Admission Record indicated the facility admitted the resident on 4/11/2024 with diagnoses including, but not limited to, fusion of spine (surgical procedure that joins two or more parts of the spine) in the lumbar region (lower end of the spine) and thoracic region (middle section of the spine), generalized muscle weakness, and difficulty in walking. A review of Resident 1 ' s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 4/17/2024, indicated Resident 1 was able to understand and make decisions, required supervision or touching assistance with eating and oral hygiene, partial or moderate assistance with personal hygiene and upper body dressing, maximal assistance with toileting hygiene, showering or bathing himself, lower body dressing, putting or taking off footwear, rolling left and right, sitting to lying, lying to sitting on the side of the bed, and was dependent on staff for transferring in and out of the tub or shower. The MDS further indicated Resident 1 has had one fall since admission with injury and had frequent episodes of urinary and bowel incontinence (lack of control over urination and defecation). A review of Resident 1 ' s History and Physical (H&P), dated 4/13/2024, indicated Resident 1 was alert and oriented. (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1 ' s Admission/Readmission Data Tool, dated 4/11/2024, indicated, dated 4/11/2024, indicated a Fall Risk Assessment was performed and indicated Resident 1 had a history of one to two falls within the last six months, with a score of two, used antihypertensive medications (medications used to control high blood pressure), with a score of one, was occasionally incontinent, with a score of two, had one to two predisposing conditions present, with a score of two, and was not at risk for falls. The fall risk assessment indicated Resident 1 scored a seven. The fall risk assessment further indicated to review and add the totals for the questions and if any answers equal more than ' zero ' , the resident is considered to be At Risk. During a concurrent interview and record review with Registered Nurse (RN) 1, on 4/25/2024, at 4:17 p.m., Resident 1 ' s Admission/Readmission Data Tool, dated 4/11/2024, was reviewed and indicated a Fall Risk Assessment was conducted on admission and indicated Resident 1 scored a seven. The fall risk assessment indicated to review and add the totals for the questions and if any answer equal more than ' zero ' , the resident is considered to be At Risk. The fall risk assessment indicated Resident 1 was not at risk for falls. RN 1 stated based off the fall risk assessment, Resident 1 is at mild to moderate risk for falls. RN 1 stated the Resident 1 ' s fall risk assessment should have been marked as yes, for at risk for falls. RN 1 further stated it is important to assess residents for falls properly so that other staff members would know what to do. RN 1 further stated if a fall risk assessment is not done properly, the facility staff would not be able to communicate a resident ' s fall risk. During a concurrent interview and record review with the Director of Nursing (DON), on 4/25/2024, at 5:21 p. m., Resident 1 ' s Admission/Readmission Data Tool, dated 4/11/2024, was reviewed and indicated a Fall Risk Assessment was conducted on admission and indicated Resident 1 scored a seven. The fall risk assessment indicated to review and add the totals for the questions and if any answer equal more than ' zero ' , the resident is considered to be At Risk. The fall risk assessment indicated Resident 1 was not at risk for falls. The DON stated Resident 1 ' s fall risk assessment should have indicated Resident 1 was at risk for falls. The DON stated it is important to have an accurate fall risk assessment to assist the nurses in completing a plan of care for the resident. The DON stated an accurate fall risk assessment provides more accurate interventions the resident may need to prevent falls from occurring. The DON further stated if the fall risk assessment is not completed accurately, there is a potential that the plan of care would not be the best fit for the resident. A review of the facility ' s policy and procedure (P&P) titled, Fall Risk Assessment, last reviewed 2/7/2024, indicated the nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and establish resident-centered fall prevention plan based on relevant assessment information.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43418 Based on observation, interview, and record review, the facility failed to assess three of three sampled residents (Resident 1, 2, and 3) for risk of entrapment (an event in which a resident is caught, trapped, or entangled in the space in or about the bed rail) from bed rails (adjustable metal or rigid plastic bars that attach to the bed that are available in a variety of types, shapes, and sizes ranging from full to one-half, one-quarter, or one-eighth lengths, i.e., grab bars, assist bars, side rails, safety rails, mobility bar) when Resident 1, 2, and 3 did not have an entrapment risk assessment performed prior to installation of a bed rail. This deficient practice had the potential to result in psychosocial harm, physical harm from entrapment (occurs when a resident is caught between the mattress and bed rail or within the bed rail itself) and death of residents. Findings: 1. A review of Resident 1 ' s Admission Record indicated the facility admitted the resident on 4/11/2024 with diagnoses including, but not limited to, fusion of spine (surgical procedure that joins two or more parts of the spine) in the lumbar region (lower end of the spine) and thoracic region (middle section of the spine), generalized muscle weakness, and difficulty in walking. A review of Resident 1 ' s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 4/17/2024, indicated Resident 1 was able to understand and make decisions, required supervision or touching assistance with eating and oral hygiene, partial or moderate assistance with personal hygiene and upper body dressing, maximal assistance with toileting hygiene, showering or bathing himself, lower body dressing, putting or taking off footwear, rolling left and right, sitting to lying, lying to sitting on the side of the bed, and was dependent on staff for transferring in and out of the tub or shower. The MDS further indicated Resident 1 has had one fall since admission with injury and had frequent episodes of urinary and bowel incontinence (lack of control over urination and defecation). A review of Resident 1 ' s History and Physical (H&P), dated 4/13/2024, indicated Resident 1 was alert and oriented. During a concurrent observation and interview with Resident 1, on 4/25/2024, at 11:42 a.m., inside Resident 1 ' s room, Resident 1 was lying down in bed with two rails, with a size of a quarter length of the bed, on both sides of the bed. Resident 1 stated the facility did not perform side rail use assessment prior to applying the side rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Certified Nursing Assistant (CNA) 1, on 4/25/2024, at 3:11 p.m., CNA 1 stated she was assigned to Resident 1 and Resident 1 has a mobility bar to help with transfers and help prevent falls. CNA 1 stated the facility beds do not come with a mobility bar and the mobility bar needs to be installed by the facility maintenance staff. CNA 1 stated nurses need to check the residents for use of the mobility bar for resident safety and check to see if the residents can get stuck on the mobility bar. During a concurrent interview and record review with Registered Nurse (RN) 1, on 4/25/2024, at 4:17 p.m., Resident 1 ' s medical record was reviewed and did not indicate a Side Rail Utilization Assessment was performed. RN 1 stated Resident 1 uses a quarter rail. RN 1 stated residents need to be assessed for use of quarter rails. RN 1 stated part of the assessment includes checking a resident ' s risk for entrapment. During a concurrent interview and record review with the Director of Nursing (DON), on 4/25/2024, at 5:21 p. m., Resident 1 ' s medical record was reviewed, and the DON confirmed there was an alert in the electronic medical record indicating Resident 1 ' s Side Rail Utilization Assessment was overdue. The DON stated she will check if the rehabilitation department uses the same form to assess a resident ' s use of side rails since the facility and the rehabilitation department do not use the same electronic medical record program. No further documentation was provided after exit from the facility. The DON stated Resident 1 has grab bars on his bed. The DON stated residents should be assessed for the use of grab bars. The DON stated it is important to assess the resident for risk of entrapment from grab bar use. The DON further stated it is important to assess residents ' safety for use of grab bars because it can potentially lead to injury or misuse. 2. A review of Resident 2 ' s Admission Record indicated the facility admitted Resident 2 on 4/23/2024 with diagnoses including, but not limited to, generalized muscle weakness and history of falling. A review of Resident 2 ' s Medical Provider Note, dated 4/25/2024, indicated Resident 2 was alert and oriented. During a concurrent observation and interview with Resident 2, on 4/25/2024, at 1:43 p.m., inside Resident 2 ' s room, Resident 2 was sitting up in bed with two rails, with a size of a quarter length of the bed, on both sides of the bed. Resident 2 stated he has two side rails on his bed, and he was not assessed for the side rail use. During a concurrent interview and record review with RN 1, on 4/25/2024, at 4:17 p.m., Resident 2 ' s medical record was reviewed, and RN 1 confirmed Resident 2 did not have an assessment for side rail use. RN 1 further stated Resident 2 should be assessed prior to side rail use. During an interview with the DON, on 4/25/2024, at 5:21 p.m., the DON stated residents should be assessed for bed rail use prior to implementation. 3. A review of Resident 3 ' s Admission Record indicated the facility originally admitted Resident 3 on 8/19/2023, and readmitted the resident on 3/11/2024, with diagnoses including, but not limited to, other lack of coordination, difficulty in walking, and history of falling. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 3 ' s MDS, dated [DATE], indicated Resident 3 had difficulty understanding and making decisions and required maximal assistance or was dependent on staff for activities of daily living, including hygiene and surface to surface transfers. During a concurrent observation and interview with Resident 3, on 4/25/2024, at 2:20 p.m., inside Resident 3 ' s room, Resident 3 was lying down in bed with two rails, with a size of a quarter length of the bed, on both sides of the bed. Resident 3 stated she does not believe she was assessed for the use of side rails. During a concurrent interview and record review with RN 1, on 4/25/2024, at 4:17 p.m., Resident 3 ' s medical record was reviewed, and RN 1 confirmed Resident 3 did not have an assessment for side rail use. RN 1 further stated Resident 3 should be assessed prior to side rail use. During a concurrent interview and record review with the DON, on 4/25/2024, at 5:21 p.m., Resident 3 ' s Physical Therapy & Plan of Treatment, dated 3/12/2024, was reviewed and did not indicate if Resident 3 was assessed for entrapment. The DON stated the rehabilitation department should have an assessment for use of a grab bar, mobility bar, or quarter rail. A review of the facility ' s policy and procedure (P&P) titled, Bed Safety and Bed Rails, last reviewed 2/7/2024, indicated the use of bed rails is prohibited unless the criteria for use of bed rails have been met. The P&P indicated for the purposes of the policy, bed rails include side rails, safety rails, and grab and or assist bars. The P&P indicated the resident assessment to determine risk of entrapment includes, but is not limited to: a. medical diagnosis, conditions, symptoms, and or behavioral symptoms b. size and weight c. sleep habits d. medications e. acute medical or surgical interventions f. underlying medical conditions g. existence of delirium (serious disturbance in mental abilities that results in confused thinking and reduced awareness of surroundings) h. ability to toilet self safely i. cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) j. communication k. mobility in and out of bed (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	l. risk of falling The P&P indicated the resident assessment also determines potential risks to the residents associated with the use if bed rails, including the following: a. accident hazards b. restricted mobility c. psychosocial outcomes