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	07/16/2024

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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42311 Based on interview and record review, the facility failed to prepare and orient a resident to ensure a safe discharge for one of three sampled residents (Resident 1) by: 1. Failing to ensure Resident 1 was discharged to a board and care (a residential home that has been licensed by the California Department of Social services to house and provide non-medical care for six elderly residents) as per physicians' order. 2. Failing to document independent living facility's contact number in Resident 1's medical record. 3. Failing to ensure Placement Coordinator (PC- assist in locating facilities in your local area that will meet your caregiving needs) was informed that physician's order was to discharge Resident 1 to board and care. These deficient practices placed Resident 1 at risk for unsafe discharge. On 7/1/2024 Resident 1 was discharged to an independent living (unlicensed facility). Findings: During a review of Resident 1's Admission Record, it indicated the facility admitted Resident 1 on 5/27/2024 with diagnoses that included chronic obstructive pulmonary disease (COPD-a chronic inflammatory lung disease that causes obstructed airflow from the lungs), type 2 diabetes mellitus (a problem in the way the body regulates and uses sugar as a fuel) and adult failure to thrive (has a loss of appetite, eats and drinks less than usual, loses weight, and is less active). During a review of Resident 1's History and Physical, dated 5/28/2024, it indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 6/2/024, it indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 was dependent to staff for toileting, shower, and needed moderate assistance with upper body dressing, personal hygiene and chair or bed to chair transfer. Resident 1 used wheelchair and was always incontinent (unable to control) of bowel and bladder functions. (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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Order Summary Report, dated 7/1/2024, it indicated an order to discharge Resident 1 on 7/1/2024 to a Board and Care. During a review of Resident 1's Discharge Summary, it indicated Resident 1 was discharged on [DATE] to a Board and Care facility. The Discharge Summary indicated board and care facility's contact number was left blank. During a review of Resident 1's Progress Notes, dated 7/1/2024 timed at 5:13 p.m., it indicated Resident 1 was picked up by Board and Care transportation. During a review of Resident 1's Progress Note, dated 7/3/2024 timed at 4:47 p.m., it indicated Social Service Director (SSD) called Family Member 2 (FM 2) and FM 2 informed SSD that Resident 1 was back at the hospital. During an interview on 7/8/2024 at 11:31 a.m., Licensed Vocational Nurse 1 (LVN 1) stated Resident 1 was discharged on [DATE] to a Board and Care facility. During an interview on 7/11/2024 at 9:07 a.m., the Assistant Director of Nursing (ADON) stated she (ADON) discharged Resident 1 to a board and care on 7/1/2024 according to physician order. The ADON stated receiving facility arranged the transportation and picked up Resident 1 on 7/1/2024. During an interview on 7/11/2024 at 9:56 a.m., the SSD stated PC informed the SSD yesterday 7/10/2024 that Resident 1 choose to be discharged on [DATE] to an independent living instead of board and care. The SSD stated Family Member 2 (FM 2) called SSD on 7/3/2024 that Resident 2 was transferred to the hospital on 7/3/2024. The SSD also stated he (SSD) forgot to document board and care contact number in Resident 1's medical record. The SSD stated it is important to document contact number for follow up calls to Resident 1. During an interview on 7/11/2024 at 10:03 a.m., PC stated she was a Placement Coordinator. PC stated she (PC) was at the facility assisting Resident 3 (another resident) to look for a placement when SSD asked her (PC) to talk to Resident 1 about board and care options. PC stated Resident 1 was offered three licensed board and care but Resident 1 chose the independent living facility which was unlicensed. PC stated Resident 1 choose the independent living facility because she just wanted a room to rent. PC stated she called the independent living facility, and the independent living facility came to the Skilled Nursing facility (SNF) to speak to Resident 1. PC stated she did not inform SSD that Resident 1 chose the unlicensed independent living facility. PC stated she just presented the options to Resident 1, and she (PC) thought SSD would follow up with Resident 1's chosen discharge place before discharging Resident 1. During an interview on 7/11/2024 at 10:43 a.m., the Social Service Assistant (SSA) stated Resident 1 was discharged to a board and care on 7/1/2024 and when Family Member 2 (FM 2) called SSD on 7/3/2024, SSA was informed by SSD that Resident 1 was discharged to an independent living facility and not a board and care. SSA stated board and care provides 24-hour assistance for medication and restroom use. The SSA stated independent living facility do not provide 24-hour assistance unless a home health service is provided. The SSA stated physician ordered Resident 1 to be discharge to board and care. The SSA stated PC did not inform Social Service that Resident 1 chose to be discharged to an independent living instead of board and care. The SSA stated nurses should verify that residents are discharged to the right location and level of care for safety. (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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/11/2024 at 10:56 a.m., the Director of Nursing (DON) stated nurses should make sure residents are discharged to the right level of care as per physician order. During an interview on 7/11/2024 at 11:52 a.m., the ADON stated there was no documented evidence in Resident 1's medical record that PC was informed that physician order was to discharge Resident 1 to board and care. During an interview on 7/16/2024 at 3:33 p.m., Certified Occupational Therapist Assistant 1 (COTA 1) stated Resident 1 needed supervision for bed to wheelchair transfer and toileting. COTA 1 stated he (COTA 1) would not recommend Resident 1 to be discharged to a residential facility for safety. During an interview on 7/16/2024 at 3:40 p.m., the DON stated Resident 1 should be discharged to board and care as per physician's order for Resident 1's safety. The DON also stated documentation should be complete. During a review of facility's PnP titled, Charting and Documentation, dated 7/2017 and reviewed on 10/31/2023, it indicated, Documented in the medical record will be objective (not opinionated or speculative), complete and accurate. During a review of facility's PnP titled, Physician Services dated 2/2021 and reviewed on 10/31/2023, indicated, Once a resident is admitted , orders for the resident's immediate care and needs can be provided by physician, physician assistant, nurse practitioner or clinical nurse specialist. The attending physician will determine the relevance of any recommended interventions from other disciplines. The physician is not obligated to accept these recommendations if he or she has a clinically valid reason for not doing so. Physician orders and progress notes are maintained in accordance with current OBRA regulations and facility policy. During a review of facility's policy and procedure titled, Resident-Initiated Transfer or discharge date d 10/2022 and reviewed on 10/31/2023, indicated, Discharge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected. It also indicated, For residents being discharged . All of the information listed above is conveyed to the receiving provider, along with a copy of the required information found at Discharge Summary as applicable. It also indicated, For resident-initiated discharges, the medical record contains: c. documented discussion with the resident or if appropriate, his or her representative, containing details of discharge planning and arrangements for post discharge care.

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42311 Based on interview and record review, the facility failed to ensure an engaged governing body was responsible for establishing and implementing policies regarding the management of the facility for one of three sampled residents (Resident 2). On [DATE] at 6 p.m., Resident 2 expired in the facility and was not picked up by mortuary services until 911 (emergency services) was called the following day of [DATE] at 8:50 a.m. This deficient practice resulted to Resident 2's dead body stayed at the facility for more than 12 hours. Findings: A review of Resident 2's Admission Record indicated the facility admitted Resident 2 on [DATE] with diagnoses that included metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood), unspecified (unconfirmed) malignant neoplasm (cells grow and divide more than they should) of the major salivary gland (produce saliva and empty it into your mouth through ducts, or small openings, it lubricates your mouth and throat, aid in swallowing and digestion, and help shield your teeth from cavity-causing bacteria) and unspecified quadriplegia (a symptom of paralysis [the inability to move one or more limbs] that affects all a person's limbs and body from the neck down). A review of Resident 2's History and Physical, undated, indicated Resident 2 did not have the capacity to understand and make decisions. A review of Resident 2's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated [DATE], indicated resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 2 required was dependent to staff for all activities of daily living (ADL-personal hygiene, bed mobility, dressing, and transfers). Resident 2 was always incontinent (unable to control) of bowel and bladder functions. A review of Resident 2's Progress Note, dated [DATE] timed at 7:04 p.m., indicated Resident 2 expired (died) on [DATE] at 6 p.m. in the facility. A review of Resident 2's Progress Note, dated [DATE] timed at 5:44 a.m., indicated multiple calls were made to mortuary services (funeral homes) but required Family member 1 (FM 1)'s consent before Resident 2's body can be picked up. A review of Resident 2's Progress Note, dated [DATE] timed at 11:40 a.m., indicated RN 2 called 911 at 8:50 a.m. to facilitate mortuary pick up. The Progress Note indicated 911 came at 9 a.m. and at 9:30 a.m. coroners' police (a public officer whose principal duty is to inquire by an inquest into the cause of death when there is reason to think the death may not be due to natural causes) came to arrange pick up. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 11:49 a.m., RN 2 stated on [DATE] at 7 a.m., Licensed Vocational Nurse 3 (LVN 3) notified RN 2 that Resident 2's body was in Resident 2's room covered with ice bags. RN 2 stated Resident 2's body was transferred to shower room at 7:30 a.m. RN 2 stated she (RN 2) do not know what to do so she called 911 to facilitate mortuary transfer because nobody would pick up Resident 2's body unless Family Member 1 (FM 1) give consent and FM 1 was not replying to phone calls. RN 2 stated 911 arrived at 9 a.m. and Los Angeles Coroners picked up Resident 2's body on [DATE] at 11:35 a.m. During an interview on [DATE] at 12:03, the Director of Nursing (DON) stated he was informed on [DATE] that Resident 2 was not picked up. The DON stated they should have called 911 sooner to pick up Resident 2. During an interview on [DATE] at 8:40 a.m., LVN 3 stated he worked on [DATE] from 11p.m to 7 a.m., LVN 3 stated he was informed that RN 1 had arranged a mortuary pick up at 10:40 p.m., to pick up Resident 2's body. LVN 3 stated Resident 2 was not picked up. LVN 3 stated there were no RN that night and they do not know what to do with the body. LVN 3 stated he was informed by RN 1 that Administrator (ADM) was already aware, but RN 1 did not provide any instruction from ADM. LVN 3 stated he do not have the coroners number and just searched it on the internet. During an interview on [DATE] at 9:07 a.m. the ADON stated RN 1 texted her (ADON) on [DATE] at 6:49 p.m. , that Resident 2 expired on [DATE] at 6 p.m. and texted again on [DATE] at 11:56 p.m., that Resident 2's body was still at the facility. The ADON stated the facility do not have a mortuary contract. The ADON stated they do not have a policy for mortuary pick up. During an interview on [DATE] at 11:06 a.m., the ADM stated he was informed the next morning on [DATE] of Resident 2's body not picked up by mortuary. The ADM stated nurses could have called him to provide assistance. The ADM stated if he was informed, he could have called the corporate for assistance. The ADM stated they do not have a policy on what to do if residents' body is not picked up by mortuary. During an interview on [DATE] at 8:18 p.m., RN 1 stated he notified ADM but forgot the time he called the ADM and admitted not documenting he called the ADM. A review of facility's policy and procedure, titled Administrative Management (Governing Body) dated , d+[DATE] and reviewed on [DATE] indicated, The governing board shall be responsible for the management and operation of the facility. The Administrator is accountable to the governing board. The governing board is responsible for but is not limited to: f. Provision of facility services and quality resident care in accordance with professional standards of practice and principles.

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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 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** 42311 Based on interview and record review, the facility failed to ensure there was accurate documentation for one of three sampled residents (Resident 1) by failing to document the independent living facility's contact number in Resident 1's medical record. This deficient practice placed Resident 1 at risk for an unsafe discharge. On 7/1/2024 Resident 1 was discharged to an independent living (unlicensed facility). Findings: During a review of Resident 1's Admission Record, it indicated the facility admitted Resident 1 on 5/27/2024 with diagnoses that included chronic obstructive pulmonary disease (COPD-a chronic inflammatory lung disease that causes obstructed airflow from the lungs), type 2 diabetes mellitus (a problem in the way the body regulates and uses sugar as a fuel) and adult failure to thrive (has a loss of appetite, eats and drinks less than usual, loses weight, and is less active). During a review of Resident 1's History and Physical, dated 5/28/2024, it indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 6/2/024, it indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 was dependent to staff for toileting, shower, and needed moderate assistance with upper body dressing, personal hygiene and chair or bed to chair transfer. Resident 1 used wheelchair and was always incontinent (unable to control) of bowel and bladder functions. During a review of Resident 1's Order Summary Report, dated 7/1/2024, it indicated an order to discharge Resident 1 on 7/1/2024 to a Board and Care. During a review of Resident 1's Discharge Summary, it indicated Resident 1 was discharged on [DATE] to a Board and Care facility. The Discharge Summary indicated board and care facility's contact number was left blank. During a review of Resident 1's Progress Notes, dated 7/1/2024 timed at 5:13 p.m., it indicated Resident 1 was picked up by Board and Care transportation. During a review of Resident 1's Progress Note, dated 7/3/2024 timed at 4:47 p.m., it indicated Social Service Director (SSD) called Family Member 2 (FM 2) and FM 2 informed SSD that Resident 1 was back at the hospital. During an interview on 7/8/2024 at 11:31 a.m., Licensed Vocational Nurse 1 (LVN 1) stated Resident 1 was discharged on [DATE] to a Board and Care facility. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/11/2024 at 9:07 a.m., the Assistant Director of Nursing (ADON) stated she (ADON) discharged Resident 1 to a board and care on 7/1/2024 according to physician order. The ADON stated receiving facility arranged the transportation and picked up Resident 1 on 7/1/2024. During an interview on 7/11/2024 at 9:56 a.m., the SSD stated PC informed the SSD yesterday 7/10/2024 that Resident 1 choose to be discharged on [DATE] to an independent living instead of board and care. The SSD stated Family Member 2 (FM 2) called SSD on 7/3/2024 that Resident 2 was transferred to the hospital on 7/3/2024. The SSD also stated he (SSD) forgot to document board and care contact number in Resident 1's medical record. The SSD stated it is important to document contact number for follow up calls to Resident 1. During an interview on 7/11/2024 at 11:52 a.m., the ADON stated there was no documented evidence in Resident 1's medical record that PC was informed that physician order was to discharge Resident 1 to board and care. During an interview on 7/16/2024 at 3:40 p.m., the DON stated Resident 1 should be discharged to board and care as per physician's order for Resident 1's safety. The DON also stated documentation should be complete. During a review of facility's PnP titled, Charting and Documentation, dated 7/2017 and reviewed on 10/31/2023, it indicated, Documented in the medical record will be objective (not opinionated or speculative), complete and accurate. During a review of facility's policy and procedure titled, Resident-Initiated Transfer or discharge date d 10/2022 and reviewed on 10/31/2023, indicated, Discharge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected. It also indicated, For residents being discharged . All of the information listed above is conveyed to the receiving provider, along with a copy of the required information found at Discharge Summary as applicable. It also indicated, For resident-initiated discharges, the medical record contains: c. documented discussion with the resident or if appropriate, his or her representative, containing details of discharge planning and arrangements for post discharge care.