

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055287	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/09/2024
NAME OF PROVIDER OR SUPPLIER  Valley Palms Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>42311</p> <p>Based on interview and record review, the facility failed to ensure the physician was notified timely for one of three sampled residents (Resident 1). On 5/30/2024 at 9:10 a.m., Resident 1 had a pulse rate (the number of times the heart beats per minute) of 126 and physician was not notified until 12:40 p.m.</p> <p>This deficient practice resulted in the delay of obtaining appropriate instructions from the physician for proper management.</p> <p>Findings:</p> <p>During a record review of Resident 1's Admission Record indicated the facility admitted Resident 1 on 5/3/2024 with diagnoses that included pneumonia (infection of the lungs), unspecified (unconfirmed) chronic obstructive pulmonary disease (COPD- a common lung disease causing restricted airflow and breathing problems) and unspecified dementia (the loss of cognitive functioning, thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities).</p> <p>During a record review of Resident 1's History and Physical dated 5/6/2024 indicated Resident 1 did not have the capacity to understand and make decisions.</p> <p>During a record review of Resident 1's Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 6/4/2024, 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 totally dependent from staff for toileting, shower and dressing. The MDS indicated Resident 1 was always incontinent (unable to control) of bowel and bladder functions.</p> <p>During a record review of Resident 1's Interact Change in Condition Evaluation dated 5/30/2024 indicated on 5/30/2024 at 9:10 a.m., Resident 1's pulse rate was 126 and at 12:20 p.m., Resident 1's pulse rate was 122. The Interact Change in Condition Evaluation indicated physician was notified at 12:40 p.m. and ordered stat (immediately) electrocardiogram (ECG- a quick test to check the heartbeat. It records the electrical signals in the heart. Test results can help diagnose heart attacks and irregular heartbeats, called arrhythmias).</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 7/24/2024 at 10:51 a.m., with the Director of Nursing (DON) Resident 1's Interact Change in Condition Evaluation dated 5/30/2024 was reviewed. The DON stated physician should have been notified at 9:10 a.m. because of elevated pulse rate. The DON stated there was a delay in notifying the physician.</p> <p>During a concurrent interview and record review on 7/24/2024 at 10:51 a.m., with the DON, facility's policy and procedure titled, Change in a Resident's Condition or Status, dated 2/2021 and reviewed on 1/30/2024, indicated, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical, mental condition and or status (example given, changes in level of care, billing, payments, resident rights). 1. The nurse will notify the resident's attending physician or physician on call when there has been a (an): d. significant change in the resident's physical, emotional, mental condition; 2. A significant change of condition is a major decline or improvement in the resident's status that: a. will not normally resolve itself without intervention by staff or by implementing standard disease- related clinical interventions (is not self-limiting). The DON stated it was their policy to immediately notify the physician of any change in vital signs (measure the basic functions of your body, including your body's temperature, blood pressure, pulse and respiratory (breathing) rate).</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>42311</p> <p>Based on interview and record review, the facility failed to develop a comprehensive care plan for one of three sampled residents (Resident 1) to address Resident 1's tachycardia (elevated pulse rate) on 5/30/2024.</p> <p>This deficient practice had the potential for delayed provision of necessary care and services.</p> <p>Findings:</p> <p>During a record review of Resident 1's Admission Record indicated the facility admitted Resident 1 on 5/3/2024 with diagnoses that included pneumonia (infection of the lungs), unspecified (unconfirmed) chronic obstructive pulmonary disease (COPD- a common lung disease causing restricted airflow and breathing problems) and unspecified dementia (the loss of cognitive functioning, thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities).</p> <p>During a record review of Resident 1's History and Physical dated 5/6/2024 indicated Resident 1 did not have the capacity to understand and make decisions.</p> <p>During a record review of Resident 1's Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 6/4/2024, 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 totally dependent from staff for toileting, shower and dressing. The MDS indicated Resident 1 was always incontinent (unable to control) of bowel and bladder functions.</p> <p>During a record review of Resident 1's Interact Change in Condition Evaluation dated 5/30/2024 indicated on 5/30/2024 at 9:10 a.m., Resident 1's pulse rate was 126 and at 12:20 p.m., Resident 1's pulse rate was 122. The Interact Change in Condition Evaluation indicated physician was notified at 12:40 p.m. and ordered stat (immediate) electrocardiogram (ECG- a quick test to check the heartbeat. It records the electrical signals in the heart. Test results can help diagnose heart attacks and irregular heartbeats, called arrhythmias).</p> <p>During a concurrent interview and record review on 7/24/2024 at 10:51 a.m., with the Director of Nursing (DON) Resident 1's Care Plans were reviewed. The DON stated there were no care plan develop to address Resident 1's tachycardia. The DON stated care plan should have been developed to list the intervention and guide nurses on what to do.</p> <p>During a record review of facility's policy and procedure titled, Comprehensive Person- Centered Care Plans dated 3/2022 and reviewed on 1/30/2024 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. The comprehensive, person-centered care plan:</p> <p>a. Includes measurable objectives and timeframes.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. Describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental (relating to the mind), and psychosocial (relating social conditions to mental health) well-being .</p> <p>c. Includes the resident's stated goals upon admission and desired outcomes.</p> <p>d. Builds on the resident's strengths; and</p> <p>e. Reflects currently recognized standards of practice for problem areas and conditions.</p> <p>10. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers</p> <p>12. The interdisciplinary team (IDT-a coordinated group of experts from several different fields who work together) reviews and updates the care plan:</p> <p>a. When there has been a significant change in the resident's condition.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>42311</p> <p>Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) for one of three sampled residents (Resident 1) by failing to ensure metoprolol tartrate (medication used to treat high blood pressure) was not given to Resident 1 on 6/2/2024 at 9 a.m., 6/3/2024 at 9 a.m. and 5 p.m., as per physician's order.</p> <p>This deficient practices had the potential to result in medication error and delay in necessary care and had the potential to result in ineffectively managed hypertension (uncontrolled elevated blood pressure) for Resident 1.</p> <p>Findings:</p> <p>During a record review of Resident 1's Admission Record indicated the facility admitted Resident 1 on 5/3/2024 with diagnoses that included pneumonia (infection of the lungs), unspecified (unconfirmed) chronic obstructive pulmonary disease (COPD- a common lung disease causing restricted airflow and breathing problems) and unspecified dementia (the loss of cognitive functioning, thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities).</p> <p>During a record review of Resident 1's History and Physical, dated 5/6/2024, indicated Resident 1 did not have the capacity to understand and make decisions.</p> <p>During a record review of Resident 1's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 6/4/2024, 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 totally dependent from staff for toileting, shower and dressing. The MDS indicated Resident 1 was always incontinent (unable to control) of bowel and bladder functions.</p> <p>During a record review of Resident 1's Physician Order, dated 5/31/2024, indicated an order for metoprolol tartrate tablet, 12.5 milligrams (mg-unit of measurement) by gastrostomy tube (g-tube, a flexible tube surgically inserted through abdomen into the stomach for feeding, fluid and medication administration) twice a day for hypertension, hold for systolic blood pressure (sbp-pressure in the arteries when the heart beats) less than 120 or heart rate less than 60.</p> <p>During a record review of Resident 1's Medication Administration Record (MAR) dated 6/2024 indicated Resident 1 was given metoprolol tartrate on the following dates and times:</p> <ol style="list-style-type: none"> <li>6/2/2024 at 9 a.m., Resident 1's blood pressure was 113/67.</li> <li>6/3/2024 at 9 a.m., Resident 1's blood pressure was 112/67.</li> <li>6/3/2024 at 5 p.m., Resident 1's blood pressure was 117/70.</li> </ol> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/24/2024 at 10:51 a.m., the Director of Nursing (DON) stated Licensed Vocational Nurse 2 (LVN 2) and LVN 3 should have held the metoprolol tartrate as per physician order to hold for sbp below 120 to prevent low blood pressure.</p> <p>During a record review of facility's policy and procedure titled, Administering Medications, dated 4/2019 and reviewed on 1/30/24 indicated, Medications are administered in a safe and timely manner. and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. The following information is checked or verified for each resident prior to administering medications: b. Vitals signs, if necessary.</p>		