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	09/24/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 42311 Based on interview and record review, the facility failed to administer insulin per physician's order to one of three sampled residents (Resident 1). This deficient practice had the potential for Resident 1 to have uncontrolled blood sugar. Findings: During a record review of Resident 1 ' s Admission Record, the Admission Record indicated the facility admitted Resident 1 on 8/12/2024 with diagnoses that included metabolic encephalopathy (problem in the brain caused by a chemical imbalance in the blood resulting to confusion and memory loss), acute respiratory failure with hypoxia (condition in which not enough oxygen passes the lungs into your blood) and diabetes mellitus (uncontrolled elevated blood sugar). During a record review of Resident 1 ' s Care Plan (CP) on at risk for uncontrolled blood sugar dated 8/12/2024, the CP indicated an intervention for diabetes medication as ordered by the physician and insulin regular human injection (act of administering a liquid, especially a drug, into a person's body using a needle and a syringe) solution per sliding scale (the dose is based on your blood sugar level just before your meal. The higher your blood sugar, the more insulin you take). During a record review of Resident 1 ' s Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 8/17/2024, the MDS indicated the resident ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. During a record review of Resident 1 ' s Physician Order dated 8/20/2024, it indicated an order for Insulin Regular Human Injection Solution 100 units per millimeter (ml- unit of measurement). Inject per sliding scale subcutaneously (beneath, or under, all the layers of the skin) before meals and at bedtime for diabetes mellitus. Rotate injection sites. Less than 70, give orange juice if resident is awake and able to swallow then notify the physician. 70-150= 0 units 151-200= give 1 units (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	201-250= give 2 units 251-300=give 4 units 301-350=give 6 units 351-400=give 8 units More than 400= notify the physician During a record review of Resident 1 ' s Medication Administration Record (MAR) dated 8/2024, the MAR indicated the following: 1. 8/29/2024 at 11:30 a.m., Resident 1 ' s blood sugar was 188. Regular insulin was not given. 2. 8/30/2024 at 9 p.m., Resident 1 ' s blood sugar was 168. Regular insulin was not given. During a concurrent interview and record review on 9/24/2024 at 8:25 a.m., with Registered Nurse 1 (RN 1), Resident 1 ' s Physician Order dated 8/2024 and MAR dated 8/2024 were reviewed. RN 1 stated on 8/29/2024 at 11:30 a.m., Resident 1 ' s blood sugar was 188 but Licensed Vocational 2 (LVN 2) documented regular insulin was not given because the blood sugar was outside of the parameter. RN 1 stated on 8/30/2024 at 9 p.m., Resident 1 ' s blood sugar was 168 but Licensed Vocational Nurse 1 (LVN 1) documented regular insulin was not given per sliding scale. RN 1 stated Resident 1 should have been given 1 unit of regular insulin on 8/29/2024 at 11:30 a.m. and on 8/30/2024 at 9 p.m. RN 1 stated Resident 1 ' s blood sugar can increase if regular insulin was not given per physician's order. During an interview on 9/24/2204 at 8:48 a.m., with the Assistant Director of Nursing (ADON), the ADON stated LVN 1 and LVN2 should have followed the physician ' s order. The ADON stated Resident 1 ' s blood sugar can go up if regular insulin was not given. During a concurrent interview and record review on 9/24/2024 at 9:35 a.m., with the ADON, facility ' s policy and procedure (PnP) titled, Administering Medications dated 4/2019 and reviewed on 7/30/2024 indicated, Medications are administered in accordance with prescribers ' orders, including any required time frame. ADON stated it is the facility ' s PnP to follow physician ' s order.