

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  02/06/2025
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>43878</p> <p>Based on interview and record review, the facility failed to follow its Policy and Procedures (P&amp;P) titled, Change in a Resident's Condition or Status, for one of three residents (Resident 1) when the facility failed to notify the Medical Doctor (MD 1) and the Family Member 1 (FM 1) that the facility did not collect the ordered urinalysis (UA- a medical test that examines urine samples) with a culture and sensitivity test (CS- tells you if bacteria are present in a sample from your body [like urine or a wound], and if so, which antibiotics are most likely to effectively kill those specific bacteria).</p> <p>This deficient practice resulted in a delay of delivery of care and services to Resident 1 who was diagnosed with a urinary tract infection (UTI- an infection in the bladder/urinary tract).</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the Admission Record indicated the facility admitted the resident on 2/24/2020 and readmitted the resident on 3/3/2023 with diagnoses including dementia (a progressive state of decline in mental abilities), UTI, hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (a condition that causes weakness or an inability to move on one side of the body), following cerebral infarction (a type of stroke that occurs when an area of brain tissue dies due to a lack of blood flow) affecting the right dominant side.</p> <p>During a review of Resident 1's Care plan, created on 2/12/2023, for bladder incontinence related to dementia with interventions that included to monitor and document for sign and symptoms of UTI, pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature. Urinary frequency, foul smelling urine, fever, chills, altered mental status, changed in behavior, change in eating patterns.</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 11/1/2024, indicated Resident 1 usually understood and was usually understood. The MDS indicated Resident 1 was always incontinent (accidentally leaking urine or stool due to a lack of bladder or bowel control) with urine and bowel.</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 review of Resident 1's Situational, Background, Appearance, and Review (SBAR), dated 12/12/2024, indicated physical aggression. MD 1 was notified on 12/12/24 at 12 a.m. with new orders for complete blood count (CBC-a group of blood tests that measure the number and size of the different cells in your blood), comprehensive metabolic panel (CMP- a blood test that gives doctors information about the body's fluid balance, levels of electrolytes like sodium and potassium, and how well the kidneys and liver are working) and UA/CS and a psychologist consultation.</p> <p>During a review of Resident 1's Physician orders, it indicated on 12/2/2024 the following physician orders:</p> <ul style="list-style-type: none"> <li>- CBC with Differential, CMP Panel one time only.</li> <li>- Culture urine one time only.</li> <li>- Urinalysis one time only.</li> </ul> <p>During a review of Resident 1's Lab Results, dated 12/13/2024, indicated CBC with differential and CMP panel was completed.</p> <p>During a review of Resident 1's General Acute Care Hospital 1 (GACH 1) records, dated 1/5/2025, the records indicated Resident 1's assessment plan indicated increase agitation and aggressive behavior with psychotic feature UTI (a UTI that manifests with symptoms resembling psychosis, such as delusions, hallucinations, confusion, or sudden changes in behavior, potentially due to the inflammatory response triggered by the infection impacting brain function).</p> <p>During a concurrent interview and record review of the SBAR, dated 12/12/2024 on 2/6/2025 at 2:42 p.m., Registered Nurse 1 (RN 1) stated Resident 1 had a history of being noncompliant with allowing staff to get UA from her. RN 1 stated when a resident refuses to get a UA done, we try later, then notify family, and try a second attempt. RN 1 stated regarding a resident's refusal to get a UA, was not sure how many times a staff try before notifying the MD. RN1 stated he thinks it is three attempts. The RN1 stated he will follow up with nursing the next day if UA was collected and if not done will notify the MD. RN 1 stated he cannot recall if MD and or FM 1 was made aware of not being able to get UA after SBAR on 12/12. RN 1 stated a UA is ordered for suspected UTI or to pinpoint why the resident is confused and off baseline. RN 1 stated when Resident 1 have a change in behavior and/or confusion, it can be a sign of a UTI. RN 1 stated if MD is not notified of the facility being unable to get UA, it can lead to a delay in care which can then lead to a UTI and can develop into sepsis. RN 1 stated cannot recall if FM 1 was notified regarding Resident 1's refusal on 12/12/24, as the family member it is FM1 right to know what is going on with R1.</p> <p>(continued on next page)</p>		

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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 an interview on 2/6/2025 at 4:05 p.m., the Director of Nursing (DON) stated if unable to get urine we contact the MD. The DON stated staff should try to obtain the UA. The rule of thumb is attempting three times then notify the MD. The DON stated the refusal and interventions should be documented. The DON stated also must document that the MD was notified of the refusal. The DON stated for Resident 1, MD 1 should have been notified and it should have been documented that Resident 1 was explained the risk and benefits and was refusing. The DON stated the MD must be notified so that they can decide what to do next. If the MD is not notified, they will not know that the UA was never obtained The DON stated she was not aware the UA was never done. The DON stated can only speculate that UA test was not communicated, and no one followed up on the lab results. If there are no results then the staff should have contacted the laboratory. The DON stated Resident 1 could have had the infection at that time and could have been treated early. The DON stated understood Resident 1 was transferred out because of a behavior and then was noted as having a UTI at the hospital. The DON stated this would be a delay in care. She would have been treated if we had gotten the labs done and if it indicated Resident 1 had a UTI.</p> <p>A review of the facility's P&amp;P titled, Charting and Documentation, last reviewed on 7/30/2024, the P&amp;P indicated our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical and or mental condition. The Nurse will notify the resident's attending physician or physician on call when there has been a:</p> <p>f. refusal of treatment or medications two (2) or more consecutive times.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>43878</p> <p>Based on interview and record review, the facility failed to complete a physician ordered urinalysis (UA- a medical test that examines urine samples) with a culture and sensitivity test (CS- tells you if bacteria are present in a sample from your body [like urine or a wound], and if so, which antibiotics are most likely to effectively kill those specific bacteria) for one of three sampled residents (Resident 1).</p> <p>This deficient practice resulted in the delay of care and services to Resident 1 who was diagnosed with a urinary tract infection (UTI- an infection in the bladder/urinary tract).</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the Admission Record indicated the facility admitted the resident on 2/24/2020 and readmitted the resident on 3/3/2023 with diagnoses including dementia (a progressive state of decline in mental abilities), UTI, hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (a condition that causes weakness or an inability to move on one side of the body), following cerebral infarction (a type of stroke that occurs when an area of brain tissue dies due to a lack of blood flow) affecting right dominant side.</p> <p>During a review of Resident 1's care plan, created on 2/12/2023, for bladder incontinence related to dementia, the care plan indicated interventions that included to monitor and document for signs and symptoms of UTI, pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, changed in behavior, and change in eating patterns.</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 11/1/2024, the MDS indicated Resident 1 usually understood and was usually understood. The MDS indicated Resident 1 was always incontinent (accidentally leaking urine or stool due to a lack of bladder or bowel control) with urine and bowel.</p> <p>During a review of Resident 1's Situational, Background, Appearance, and Review (SBAR), dated 12/12/2024, the SBAR indicated physical aggression. MD 1 was notified on 12/12/24 at 12 a.m. with new orders for complete blood count (CBC - a group of blood tests that measure the number and size of the different cells in your blood), comprehensive metabolic panel (CMP- a blood test that gives doctors information about the body's fluid balance, levels of electrolytes like sodium and potassium, and how well the kidneys and liver are working), UA/CS and a psychologist consultation.</p> <p>During a review of Resident 1's Physician orders indicated the following physician orders on 12/2/2024:</p> <ul style="list-style-type: none"> <li>- CBC with Differential, CMP Panel one time only.</li> <li>- Culture urine one time only.</li> </ul> <p>(continued on next page)</p>		

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