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	01/22/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38552 Based on observation, interview, and record review, the facility failed to ensure three of six sampled residents (Resident 45, Resident 53, and Resident 4) were treated with respect and dignity in a manner that promotes maintenance or enhancement of his or her quality of life for by failing to: 1. Ensure Resident 45's sides and thighs were not exposed and visible from visitors, other residents, and staff when the resident was transported from the shower back to his room investigated under Dignity care area. 2. Ensure Resident 53's bare back and side were not exposed and visible from the hallway by staff, residents, and visitors. 3. Maintain Resident 4's right to wear own clothing. These deficient practices had the potential to result in a decrease in the residents' psychosocial well-being. Findings: a. During a review of Resident 45's Admission Record, the Admission Record indicated the facility originally admitted the resident on 11/13/2024 and readmitted on [DATE] with diagnoses including multiple sclerosis (MS- a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar [glucose]), and chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should). During a review of Resident 45's Minimum Data Set (MDS, a resident assessment tool), dated 12/28/2024, the MDS indicated the resident made self understood and had the ability to understand others. The MDS indicated Resident 45 required substantial/maximal assistance with toileting hygiene and the ability to transfer to and from a bed to a chair. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 1/18/2025 at 8:48 a.m., with the Assistant Director of Nursing (ADON), Resident 45 was sitting on a shower chair coming out of the shower room, transported by Certified Nursing Assistant 10 (CNA 10), was covered with one sheet, and a towel over his head. Resident 45 stated no peeking, no peeking. Observed CNA 2 continue to transport Resident 45, with his sides exposed, back to his room. The ADON stated Resident 45 had only one sheet cover around his body and his sides were uncovered, leaving it exposed. The ADON stated Resident 45 should have been covered well. During an interview on 1/18/2025 at 10:30 a.m., with CNA 5, CNA 5 stated she only used one sheet cover with a hole and a towel to cover Resident 45's head. CNA 5 stated she only uses one sheet cover for all her residents but Resident 45 was tall or large that it does not cover all of him. CNA 5 stated next time she will use two for Resident 45. CNA 5 stated covering the resident with the linen is used for the privacy of the resident. CNA 5 stated if she does not fully cover the resident then the resident's sides will be exposed. During an interview on 1/21/2025 at 10:30 a.m , with the Director of Staff Development (DSD), the DSD stated CNAs are trained to provide privacy to the residents. The DSD stated residents should be fully draped when CNAs transfer residents from the shower and back to the residents' room. The DSD stated it is important for the CNAs to provide privacy to the residents when they are transporting residents to preserve the resident's dignity and honor the resident's rights to privacy. The DSD stated when CNAs do not fully drape the residents the residents' privacy is violated. The DSD stated their facility has a poncho and a facility gown the residents can use and can use more if needed as some residents may need more to be covered. During an interview on 1/22/2025 at 12:57 p.m., with the Director of Nursing (DON), the DON stated the residents should be fully draped because the residents could potentially feel cold and is a dignity issue. The DON stated all residents should be provided cover and their body should not be exposed. During a review of the facility policy and procedure (P&P) titled, Dignity, last reviewed 7/30/2024, the P&P indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Residents are treated with dignity and respect at all times. The facility culture supports dignity and respect for residents. When assisting with care, residents are supported in exercising their rights. For example, residents are provided with a dignified dining experience. Staff promote, maintain and protect resident privacy, including bodily privacy. 44244 b. During a review of Resident 53's Admission Record, the Admission Record indicated the facility admitted the resident on 4/28/2021 and readmitted the resident on 12/10/2024 with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), end stage renal disease (ESRD - irreversible kidney failure), and dependence on hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), glaucoma (an eye condition causing gradual loss of sight), and dementia (a progressive state of decline in mental abilities). (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 53's MDS, dated [DATE], the MDS indicated the resident was able to understand others and was able to make herself understood. The MDS further indicated the resident required partial/moderate assistance from staff for oral hygiene, upper and lower body dressing, personal hygiene, and bed mobility; and was independent with eating. During a review of Resident 53's Care Plan (CP) regarding the resident is at risk for decline in activities of daily living, upper body/lower body dressing, initiated 12/11/2024, the CP indicated the resident had muscle weakness and was receiving occupational therapy for self-care management skills. During a review of Resident 53's CP titled, The resident has a right to a dignified existence ., initiated 4/14/2022, the CP indicated the resident rights were ongoing and the resident had a right to privacy and to be treated with dignity. During an observation on 1/19/2025 at 8:26 a.m., observed Resident 53 from the hallway with the privacy curtains drawn back to the wall. Observed the resident was sitting up in bed and leaning forward over the bedside rolling table eating. Observe the resident wearing a hospital style gown that was falling forward and not secured at the back. Observed the resident's bare back and entire left side down to the thigh was exposed to any passersby including staff, visitors, and residents in the hallway. During a concurrent observation and interview on 1/19/2025 at 8:35 a.m., with the Infection Preventionist (IP), observed the IP enter Resident 53's room and greeted Resident 53 and the resident's two roommates. Observed Resident 53's bare back and side continued to be exposed. Observed the IP pick a piece of paper up off the floor, place it in the trash, and exit the room. Observed the IP did not pull the curtains for privacy or adjust Resident 53's gown. Upon exiting the room, the IP stated she did not notice Resident 53's back and side were exposed and visible from the hallway with the privacy curtain open, but she should have. The IP stated it was every staff members responsibility to ensure residents are covered for their dignity. The IP stated residents have a right to not have their bare skin showing to people passing by in the hallway. Observed the IP re-enter Resident 53's room and pull the privacy curtain closed. Resident 53 attempted, but was unable, to tie the gown at the back. Resident 53 stated the gown was so big. The IP pulled Resident 53's gown to cover her side and back and secured the tie closure at the neck and waist. Resident 53 repeated the words thank you three times to the IP. During a concurrent interview and record review on 1/20/2025 at 9:07 a.m., with the Director of Nursing (DON), the DON reviewed the facility policy and procedures regarding resident dignity. The DON stated any staff entering a resident's room should assess the residents for dignity issues because it is their job to protect the residents. The DON stated a dignity issue should be corrected right away. The DON stated when Resident 53's back and side were naked and exposed the resident could also have been cold. The DON stated when staff did not recognize and correct Resident 53's exposed body it could potentially lead to the resident feeling self-conscious leading to depression and psychosocial issues. The DON stated the facility policy was not followed when Resident 53's gown was left open, and her body was exposed. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility policy and procedure (P&P) titled, Dignity, last reviewed 7/30/2024, the P&P indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Residents are treated with dignity and respect at all times. The facility culture supports dignity and respect for residents. When assisting with care, residents are supported in exercising their rights. For example, residents are provided with a dignified dining experience. Staff promote, maintain and protect resident privacy, including bodily privacy. 43988 c. During a review of Resident 4's Admission Record, the Admission Record indicated the facility originally admitted the resident on 2/10/2024 and readmitted in the facility on 6/18/2024 with diagnoses including cerebral infarction (stroke, loss of blood flow to a part of the brain), dysphagia (difficulty swallowing), and generalized muscle weakness. During a review of Resident 4's History and Physical (H&P), dated 2/12/2024, the H&P indicated the resident did not have the capacity to make decisions. During a review of Resident 4's MDS, dated [DATE], the MDS indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated the resident required substantial/maximal assistance with bed mobility; total assistance with all other activities of daily living (ADLs, routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent observation and interview on 1/18/2025 at 12:20 p.m. outside Resident 4's room with Restorative Nursing Assistant 2 (RNA 2), RNA 2 verified Resident 4 was sitting up on the wheelchair and was only wearing a gown with a blue shirt underneath. RNA 2 was unable to tell who placed the resident on the wheelchair. RNA 2 stated Resident 4 should have been wearing her own clothing while sitting up in the wheelchair to preserve her self-esteem and dignity. RNA 2 stated when getting resident's out of bed, they should be wearing clothing of their choice so they would look and feel good about themselves. During an interview on 1/18/2025 at 12:25 p.m. Certified Nursing Assistant 12 (CNA 12), CNA 12 stated he placed Resident 4 on the wheelchair with the assistance of Restorative Nursing Assistant 1 (RNA 1) to prepare the resident for lunch. CNA 12 stated they should have put on Resident 4's clothing of choice prior to getting out of bed onto the wheelchair to maintain their dignity. During an interview on 1/18/2025 at 2:00 p.m., Registered Nurse 1 (RN 1) stated all residents should be wearing their own clothing when up on a wheelchair or during the day unless it is their personal preference not to wear own clothing. RN 1 stated the purpose of wearing own clothing of choice is to maintain their self-worth, independence, and dignity. RN 1 stated Resident 4 should have been wearing her own clothing while up in the wheelchair to maintain her self-worth and dignity. During a review of the facility's policy and procedure (P&P) titled, Dignity, last reviewed 7/30/2024, the P&P indicated each resident shall be cared for in a manner that promotes and enhances his or sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. The P&P further indicated when assisting with care, residents are supported in exercising their right by encouraging them to dress in clothing that they prefer.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 44244 Based on interview and record review, the facility failed to ensure one of five sampled residents (Residents 83) reviewed for unnecessary (any medication in excessive dose, excessive duration, without adequate monitoring) medications was free from the use of unnecessary psychotropic (any medication capable of affecting the mind, emotions, and behavior) medications in accordance with the facility policy and procedure by failing to obtain an informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for Resident 83's use of lorazepam (a psychotropic medication use to treat feelings of anxiousness). This deficient practice had the potential to result in the use of unnecessary psychotropic drugs and adverse effects (an undesired and harmful result of a treatment or intervention, such as a medication or surgery) of the medication. Findings: During a review of Resident 83's Admission Record, the Admission Record indicated the facility admitted the resident on 10/1/2024, with diagnoses including depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (a mental health condition that may result in restlessness, irritability, feelings of nervousness, panic, and fear), and genetic torsion dystonia (a movement disorder that causes involuntary muscle contractions and twisting movements). During a review of Resident 83's History and Physical (H&P), dated 10/3/2024, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 83's Minimum Data Set (MDS, a resident assessment tool), dated 1/3/2025, the MDS indicated the resident had the ability to understand others and had the ability to make herself understood. During a review of Resident 83's Order Summary Report, the report indicated an order for lorazepam oral tablet 0.5 milligrams (mg, a unit of measure), give one tablet by mouth two times a day for anxiety manifested by the inability to stay still, dated 11/14/2024. During an interview on 1/20/2024 at 2:15 p.m. with Licensed Vocational Nurse 7 (LVN 7), LVN 7 stated she care for Resident 83 and the resident was administered lorazepam twice a day because of the resident's inability to sit still. LVN 7 stated lorazepam is a psychotropic medication and all medications that affect behavior must have informed consent. LVN 7 stated she would ask the Director of Nursing (DON) to provide Resident 83's informed consent for lorazepam. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/20/2024 at 2:45 p.m. with the DON, the DON reviewed the facility policy regarding psychotropic medications. The DON stated after a thorough search, there was no documented evidence of informed consent for Resident 83's use of lorazepam. The DON stated when lorazepam is started or restarted the physician must obtain informed consent from the resident or resident representative to make sure the resident is aware of the possible side effects of the medications. The DON stated lorazepam has a risk of causing adverse effects like dizziness or habitual dependence. The DON Stated when consent was not obtained for Resident 83's use of lorazepam, there was a potential that the resident would not be able to identify and report the adverse effects of the medication. The DON stated the facility policy and procedure was not followed. During an interview on 1/20/2025 at 2:56 p.m. with Resident 83, the resident stated she takes lorazepam because she is really restless and moves constantly without it. Resident 83 stated nobody had explained or discussed with her the possible side effects of the use of lorazepam. During a review of the facility policy and procedure titled, Psychotropic Medication Use, last reviewed 7/30/2025, the policy indicated a psychotropic medication is any medication that affects the brain activity associated with mental processes and behavior. Anti-anxiety medications are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications. Residents are involved in the medication management process. Psychotropic medication management includes: A. Indications for use B. Dose C. Duration D. Adequate monitoring for efficacy and adverse consequences E. Preventing, identifying and responding to adverse consequences Residents have the right to decline treatment with psychotropic medications.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 44244 Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of resident needs and preferences by failing to ensure the call light (CL, an alerting device for nurses or other nursing personnel to assist a patient when in need) was withing reach for one of two sampled residents (Resident 16) reviewed under the Environment task. This deficient practice had the potential to result in the delay of care and services and possible injury to residents when they are unable to summon health care workers. Findings: During a review of Resident 16's Admission Record, the Admission Record indicated the facility admitted the resident on 6/9/2023 and readmitted the resident on 7/1/2024 with diagnoses that included dementia (a progressive state of decline in mental abilities), difficulty walking, muscle weakness, history of falling, and metabolic encephalopathy (an alteration in consciousness due to brain dysfunction). During a review of Resident 16's Minimum Data Set (MDS - resident assessment tool) dated 12/11/2024, the MDS indicated the resident was able to understand others and was able to make himself understood. The MDS further indicated the resident required partial/moderate assistance from staff for toileting, dressing, and personal hygiene. During a review of Resident 16's Care Plans (CP) titled, (Resident 16) has had an actual fall with no injury ., initiated 2/12/2024, the CP indicated to provide fall precautions and place the call light within reach. During a review of Resident 16's CP regarding the resident is at risk for falls related to . dementia, psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) anxiety (a mental health condition that may result in restlessness, irritability, feelings of nervousness, panic, and fear), .muscle weakness, .vision impairment ., initiated 6/10/2023, the CP indicated to anticipate the needs of the resident and provide a safe environment with a working and reachable call light. During an observation on 1/18/2025 at 8:42 a.m., observed Resident 16 lying in bed asleep. Observe the resident's call light was placed on the drawer handle of the nightstand to the left of the resident's bed and not within reach of the resident. Observed Certified Nursing Assistant 3 (CNA 3) enter and exit Resident 16's room. During a concurrent observation and interview on 1/18/2025 at 8:55 a.m., with CNA 3, observed CNA 3 returned to Resident 16's room. CNA 3 stated Resident 16's CL was on the nightstand and was not within reach of the resident. CNA 3 stated she was sorry the CL was out of reach. CNA 3 stated the resident is confused and cannot see. CNA 3 stated Resident 16 should have the CL and he did not. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 1/19/2025 at 12:25 p.m., observed Resident 16 asleep and sitting in a wheelchair next to the foot of the bed. Observed the CL was clipped to the bed sheet near the pillow and out of reach of the resident. During a concurrent observation and interview on 1/19/2025 at 12:30 p.m. with CNA 3, CNA 3 entered Resident 16's room and stated she took the resident to the activities room in the morning and the activities staff had returned the resident to his room. CNA 3 stated the activities staff did not place Resident 16's CL within reach when they returned him to his room, but they should have because the resident cannot see. CNA 3 clipped the CL to Resident 16's jacket and the resident moved his hand over the CL. CNA 3 stated it was important for Resident 16 to have the CL to call for assistance from staff. During an interview on 1/19/2025 at 12:35 p.m., with Certified Nursing Assistant 9 (CNA 9) in the activities room, CNA 9 stated he returned Resident 16 to his room and forgot to place the CL within reach of the resident. CNA 9 stated the CL should be within reach of residents at all times to be able to communicate with staff for any needs the resident may have. CNA 9 stated it was especially important to have the CL within reach in case of an emergency so staff is able to attend to the resident right away. During a concurrent interview and record review on 1/20/2025 at 9:07 a.m., with the Director of Nursing (DON), the DON reviewed the facility policy and procedure regarding CLs. The DON stated the CL should be within reach of resident's while in bed or sitting in a wheelchair next to the bed and the resident should know where the CL is located. The DON stated the importance of the CL is that a resident needs to be able to call for help. The DON stated when a resident does not have a CL they may feel bad or need help and nobody would be able to address their needs or wants. The DON stated when staff does not attend to resident needs, it may result in the resident having feelings of frustration. The DON stated resident frustration may result in behavior issues leading to a negative emotional effect and potentially lead to resident's trying to help themselves leading to a fall or injury from an accident. The DON stated the facility policy was not followed when Resident 16 didn't have access to the CL. During a review of the facility policy and procedure (P&P) titled, Call Light, last reviewed 7/30/2024, the P&P indicated residents are provided with a measure to call staff for assistance through a communication system that directly calls a staff member or a centralized work station. The purpose of the procedure is to ensure timely responses to the resident's requests and needs. Each resident is provided a means to call staff directly for assistance from their bed and from the floor. During a review of the facility P&P titled, Falls and Fall Risk, Managing, last reviewed 7/30/2024, the P&P indicated based on previous evaluations and current data, the nursing staff will identify interventions related to resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Resident conditions that may contribute to the risk of falls include cognitive impairment and visual deficits.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for one of 1 resident (Resident 247) investigated under the pain management care area by failing to develop a care plan addressing the resident's screaming behavior. This deficient practice had the potential to cause a delay in the delivery of necessary care and services the resident need. Findings: During a review of Resident 247's Admission Record, the Admission Record indicated the facility admitted the resident on 1/10/2025 with diagnoses including history of falling, dementia (a progressive state of decline in mental abilities), and generalized muscle weakness. During a review of Resident 247's History and Physical (H&P), dated 1/13/2025, the H&P indicated the resident did not have the capacity to make decisions. During a review of Resident 247's Minimum Data Set (MDS - a resident assessment tool), dated 1/14/2025, the MDS indicated the resident had moderately impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated the resident required supervision or touching assistance with eating and oral hygiene; partial/moderate assistance with upper body dressing; total assistance with lower body dressing; substantial/maximal assistance with all other activities of daily living (ADLs, routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 247's care plans (CP), there was no documented evidence that a CP was developed and implemented addressing Resident 247's screaming behavior. During a review of Resident 247's Order Summary Report, the Order Summary Report indicated the following physician's orders: - 1/11/2024: Acetaminophen oral tablet 325 milligrams (mg - a unit of measurement) give 1 tablet by mouth every six (6) hours as needed for pain level 1 to three (3) not to exceed 3 grams (gm - a unit of measurement) of acetaminophen in 24 hours from all sources. - 1/11/2024: Acetaminophen oral tablet 325 milligrams (mg - a unit of measurement) give 2 tablets by mouth every 6 hours as needed for pain level four (4) to 6 not to exceed 3 gm of acetaminophen in 24 hours from all sources. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 1/11/2025: Norco oral tablet (a strong type of pain medicine which contains a combination of acetaminophen and hydrocodone [an opioid {a broad group of medicines used to relieve pain but can lead to addiction} pain medication] give 1 tablet by mouth every 6 hours as needed for pain level seven (7) to ten (10) out of 10 not to exceed 3 gm of acetaminophen in 24 hours from all sources. Do not give if respiratory rate is less than 12 or drowsy then notify physician. During an observation on 1/18/2025 at 9:15 a.m., 1/19/2025 at 10:00 a.m., and 1/20/2025 at 10:50 a.m. outside Resident 247's room, observed Resident 247 screaming for assistance due to pain but declined pain medication when offered by staff stating she was not in pain. During an interview on 1/20/2025 at 11:10 a.m. with Licensed Vocational Nurse 7 (LVN 7), LVN 7 stated she was made aware Resident 247 was in pain but declined when offered pain medication denying pain. During a concurrent observation and interview on 1/20/2025 at 11:25 a.m., inside Resident 247's room with Registered Nurse 1 (RN 1), observed Resident 247 lying in bed in supine position. Resident 247 stated she was not in pain and the screaming was just because she wanted to scream and declined to be interviewed further. During a concurrent interview and record review on 1/20/2025 at 3:30 p.m., reviewed Resident 247's electronic health record including care plans if Resident 247's screaming behavior was addressed with Registered Nurse 2 (RN 2). RN 2 verified there was no care plan developed and implemented addressing Resident 247's screaming behavior. RN 2 stated licensed nurses are responsible in the development of care plans if there is a change of condition or behavior issues with a resident and are reviewed and revised by the MDS Coordinator as needed. RN 2 stated there should have been a care plan developed and implemented addressing Resident 247's screaming behavior so the staff would be aware of the care the resident needed to prevent delay in the delivery of care and services Resident 247 needed. During an interview on 1/20/2025 at 4:30 p.m. with the Director of Nursing (DON), the DON stated licensed nurses are responsible in the development of care plans if there are issues that needed to be addressed. The DON stated there should have been a care plan developed and implemented addressing Resident 247's screaming behavior and refusal of any type of care so the necessary care and services can be provided to the resident and prevent a delay. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, last reviewed 7/30/2024, the P&P 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 P&P further indicated - The comprehensive care plan includes: a. Measurable objectives and timeframes b. Describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, [NAME], and psychosocial well-being (continued on next page)

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	055287	A. Building B. Wing	01/22/2025

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Valley Palms Care Center	13400 Sherman Way N Hollywood, CA 91605

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Care plan interventions are chosen after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. - Interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 43988 Based on interview and record review, the facility failed to provide care and services necessary to maintain good nutrition for one of one sampled resident (Resident 242) investigated under the activities of daily living (ADLs - routine/tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves) care area by failing to ensure Certified Nursing Assistant 9 (CNA 9) provided assistance to Resident 242 with meals. This deficient practice had the potential to result in Resident 242 having weight loss, dehydration, or nutritional problems. Findings: During a review of Resident 242's Admission Record, the Admission Record indicated the facility originally admitted the resident on 1/14/2025, with diagnoses including cerebral infarction (stroke - loss of blood flow to a part of the brain), dementia (a progressive state of decline in mental abilities), and generalized weakness. During a review of Resident 242's History and Physical (H&P), dated 1/17/2025, the H&P indicated Resident 242 did not have the capacity to understand and make decisions. During a review of Resident 242's Admission/Readmission Data Tool, dated 1/14/2025, the Admission/Readmission Data Tool indicated Resident 242 was alert with trouble keeping track of thoughts and rambling but able to understand and sometimes understood by others. The Admission/Readmission Data Tool indicated Resident 242 required one person assistance with bed mobility and two-person assistance with ADL transferring, and extensive physical assistance with eating. During a review of Resident 242's baseline care plan (CP) dated 1/14/2024, the baseline CP on functional status under functional abilities and goals indicated Resident 242 required one-person physical assist with eating. During an observation on 1/18/2025 at 12:10 p.m., inside Resident 242's room, observed Resident 242's breakfast tray remained on top of the overbed table and untouched. When asked, Resident 242 mumbled and responds inappropriately. During an interview on 1/18/2025 at 12:25 p.m. with CNA 9, CNA 9 verified that Resident 38's breakfast tray remained untouched inside the room. CNA 9 stated he positioned Resident 242 for breakfast after providing ADL care, but Resident 38 did not seem to want to eat and was not touching the food. CNA 9 stated Resident 242 was unable to follow instructions. CNA 9 stated if a resident did not want to eat, food alternatives can be offered to the resident and/or provide assistance with the meals. CNA 9 stated he should have tried to assist Resident 242 with eating during breakfast meal. CNA 9 stated if Resident 242 do not eat properly the resident would not get enough nutrition and affect her health or even have weight loss. (continued on next page)

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	055287	A. Building B. Wing	01/22/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/20/2025 at 3:45 p.m., Registered Nurse 1 (RN 1) stated the staff are supposed to assist the resident with eating if they are unable to eat by themselves or refuse to eat. The staff have to offer alternate menu or offer assistance to resident with eating. RN 1 stated CNA 9 should have assisted Resident 242 with eating during breakfast or offered assistance with eating as Resident 242 was unable to follow instructions and unable to assist herself with eating as it placed the resident at risk for altered nutrition and weight loss for not eating well as well as further skin breakdown. During an interview on 1/20/2025 at 5:30 p.m the Director of Nursing (DON) stated if a resident is unable to eat by themselves or unable to follow instructions, the staff must provide assistance to the resident with eating. The DON stated the staff has to offer an alternate menu and request in the kitchen and/or provide assistance with eating. The DON stated CNA 9 should have provided assistance to Resident 242 with eating or tried to assist if Resident 242 did not seem to want to eat or touch the food by offering the food. The DON stated if Resident 242 was not eating, it placed the resident at risk for malnutrition, weight loss, dehydration, worsening of pressure ulcer. During a review of the facility's policy and procedure (P&P) titled, assistance with Meals, last reviewed 7/30/2024, the P&P indicated residents shall receive assistance with meals in a manner that meets the individual need of each resident. The P&P further indicated residents who cannot feed themselves will be fed with attention to safety, comfort and dignity. During a review of the facility's P&P titled, Activities of Daily Living (ADL), Supporting, last reviewed 7/30/2024, the P&P indicated residents will be provided wit8h care, treatment, sand services as appropriate to maintain or improve their ability to carry out ADLs. The P&P further indicated appropriate care, and services will be provided for residents who are unable to carry out ADLs independently including appropriate support and assistance with dining (meals and snacks).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38552 Based on interview and record review, the facility failed to provided needed care and services that are resident-centered for one of one sampled resident (Resident 8) reviewed under General care area when the facility failed to follow up Resident 8's lab draw for phenobarbital (medication used to control seizure [(a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]) as ordered by the physician. This deficient practice had the potential to result in under treatment may cause ineffective seizure control or over treatment which may cause toxicity. Findings: During a review of Resident 8's Admission Record indicated the facility originally admitted the resident on 8/22/2016 and readmitted on [DATE] with diagnoses including epilepsy (seizures), anxiety disorder (an abnormal condition characterized by persistent and excessive worries that interfere with daily activities), and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). During a review of Resident 8's Minimum Data Set (MDS, a resident assessment tool), dated 10/15/2024, indicated the resident had the ability to understand and make decisions. The MDS indicated the resident required partial/moderate assistance with sit to stand, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer. During a review of Resident 8's physician orders indicated: - Phenobarbital oral tablet 30 milligrams (mg, a unit of measurement), give one tablet by mouth two times a day for seizure related to epilepsy. - Phenobarbital, sent uncollected 10/16/2024 at 12:01 a.m., one time only related to epilepsy, dated 10/15/2024. - Phenobarbital every six months, October/April, dated 10/15/2024. During a review of Resident 8's care plan focus on seizure disorder, revised on 7/20/2023, indicated the resident with goals of maintaining lab values within therapeutic range per MD. The care plan indicated interventions including to monitor labs and report any subtherapeutic or toxic results to the MD. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/21/2025 at 9:10 a.m., with the Assistant Director of Nursing (ADON), the ADON stated there were no notes why the phenobarbital was not done and no lab results for the phenobarbital lab draw ordered on 10/15/2024. The ADON stated if the phenobarbital is low it may cause harm to the resident with the possibility for increase episodes of seizure, risk for aspiration and/or injury. The ADON stated if the phenobarbital is high resident may get immune of the dose and may need to get a different medication. The ADON stated charge nurse, all licensed nurses is responsible for addressing in checking the labs and should have a good communication. The ADON stated they have a desk nurse twice a week that would check it, but it is the responsibility of the charge nurses to follow up. During an interview on 1/22/2025 at 12:59 p.m., the Director of Nursing (DON), the DON stated the facility's process when a lab draw is ordered starts with the licensed nurse from the day before, 11 p.m. to 7 a.m. shift. The DON stated the licensed nurse checks the requisition for so the phlebotomist (a medical professional who collects blood from patients and prepare the samples for testing) would not miss anyone. The DON stated once the phlebotomist arrives and collects the blood, they would inform the charge nurse which residents were not drawn, what the reason was, and for residents not drawn the licensed nurse would do a follow up with the resident's physician. During a review of the facility's policy and procedure (P&P) titled, Seizures and Epilepsy - Clinical Protocol, last reviewed 7/30/2024, indicated the nurse shall assess and document/report the resident's last blood level of any anticonvulsants being given. During a review of the facility's P&P titled, Lab and Diagnostic Test Results - Clinical Protocol, last reviewed 7/30/2024, indicated the staff will process requisitions and arrange for tests. The P&P indicated a nurse will try to determine whether the test was done as a routine screen or follow-up; to assess a condition change or recent onset of signs and symptoms; or to monitor drug level.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on observation, interview, and record review the facility failed to ensure resident received care consistent with professional standards of practice to prevent pressure injury (PI - the breakdown of skin integrity due to pressure) for three (3) of four (4) sampled residents (Residents 242, 24, and 26) investigated under pressure injury by: 1. Failing to ensure Resident 242 was provided a low air loss mattress (LALM - a mattress that helps prevent and treat pressure wounds by circulating air and relieving pressure on the body) when the resident had Stage 4 PI (full thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) on the right buttock upon admission to the facility. 2. Failing to perform an accurate assessment of Resident 242's Stage 4 PI. 3. Failing to develop and implement a baseline care plan addressing Resident 242's Stage 4 PI on the buttock. 4. Failing to follow the manufacturer guideline for LALM for Residents 24 and 26. These deficient practices placed Resident 242 at risk for developing pressures injuries and placed Residents 242, 24, and 26 at risk for worsening of their current PIs. Findings: 1. During a review of Resident 242's Admission Record, the Admission Record indicated the facility originally admitted the resident on 1/14/2025, with diagnoses including stage 3 pressure ulcer (full thickness loss of skin, dead and black tissue may be visible) on the right buttock, dementia (a progressive state of decline in mental abilities), and generalized weakness. During a review of Resident 242's History and Physical (H&P) dated 1/17/2025, the H&P indicated Resident 242 did not have the capacity to understand and make decisions. During a review of Resident 242's Admission/Readmission Data Tool dated 1/14/2025, the Admission/Readmission Data Tool indicated Resident 242 was alert with trouble keeping track of thoughts and rambling but able to understand and sometimes understood by others. The Admission/Readmission Data Tool indicated Resident 242 required one person assistance with bed mobility and two-person assistance with ADL transferring, and extensive physical assistance with eating. The Admission Readmission Data Tool indicated Resident 242 had a stage 3 pressure ulcer on the right buttock. During a review of Resident 242's Braden Score for Predicting Pressure Sore Risk dated 1/14/2025, the Braden Score for Predicting Pressure Sore Risk indicated Resident 242 is at risk for developing pressure ulcers. During a review of Resident 242's Order Summary Report, the Order Summary Report indicated the following physician's orders: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 1/14/2025 and discontinued 1/19/2025: Thera honey external gel (medical-grade honey dressing) apply to apply to right buttock wound topically one time a day for right buttock wound. - 1/14/2025 and discontinued 1/19/2025: Buttocks stage 4 pressure injury: Cleanse with normal saline (wound cleansing agent) or wound cleanser, apply skin prep to peri wound skin and adhesive area, apply hydrogel (type of wound care agent) impregnated gauze lightly filling depth, cover with foam or border gauze every three (3) days and as needed one time a day for wound management. During a concurrent observation and interview on 1/19/2025 at 9:40 a.m., inside Resident 242's room with Licensed Vocational Nurse 6 (LVN 6), LVN verified Resident 242 did not have a LALM for Stage 4 PI. LVN 6 stated Resident 242 should have been placed on a LALM to prevent worsening of the PI. During dressing change of Resident 242's PI on the right buttock, LVN 6 stated Resident 242's wound did not have any drainage and was slightly open. LVN 6 stated the wound did not have any drainage and was presenting as a Stage 2 (partial-thickness loss of skin, presenting as a shallow open sore or wound). During a concurrent interview and record review on 1/19/2025 at 10 a.m. with LVN 6, reviewed Resident 242's physician orders and skin assessment. LVN 6 verified the physician's order indicated treatment for Stage 4 PI. LVN 6 stated he did not know how the wound look like from admission until 1/19/2025. LVN 6 stated he will reclassify the PI as a Stage 4 PI presenting as a Stage 2. LVN 6 verified there was no skin assessment done after the resident was admitted to the facility. LVN 6 stated there should have been a thorough skin assessment completed after Resident 242 was admitted . LVN 6 verified there was no physician's order for the placement of LALM. LVN 6 stated there should have been a physician's order to place Resident 242 on a LALM for proper management of the PI and to prevent worsening of the PI. LVN 6 stated there should have been a through skin assessment completed on Resident 242 upon admission to ensure the proper treatment orders have been obtained from the physician. During an interview on 1/19/2025 at 4:10 p.m. with LVN 3, LVN 3 stated the treatment nurse for the day completes a thorough skin assessment of residents focusing on PI the day after admission including measuring the wound, and obtaining pictures which is directly uploaded into the electronic health record (EHR), and obtain orders from the physician such as the proper treatment and placing the residents on LALM. LVN 3 stated Resident 242's skin assessment was not completed the day after admission; it should have been completed the day after admission to ensure proper treatment was provided to Resident 242's PI. LVN 3 stated if Resident 242 did not have the proper treatment and LALM, it placed the resident at risk for development of PI and/or worsening on the current PI. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/19/2025 at 4:40 p.m., reviewed Resident 242's physician's order, and care plans with the Assistant Director of Nursing (ADON). The ADON verified there was no physician's order to place Resident 242 on LALM since admission, no baseline care plan developed addressing Resident 242's Stage 4 PI on the right buttock, and a thorough skin assessment was not completed. The ADON stated complete skin assessments are completed the day after admission and document in the EHR, notify the physician of the resident's wounds, and obtain an order for placement of LALM and proper treatment. The ADON Resident 242 should have been placed on a LALM as it had the potential for development and/or worsening of PI. The ADON stated a baseline care plan should have been developed and implemented within 48 hours of admission addressing Resident 242's PI so the staff would be aware of the proper precautions and interventions the resident needs to prevent development and/or worsening of Resident 242's PI. The ADON stated the skin assessment should have been completed the day admission as it placed the resident at risk for not receiving the necessary care and services needed which may lead to worsening of the PI. During a review of the facility's policy and procedure (P&P) titled, Pressure Ulcers/Skin Breakdown - Clinical Protocol, last reviewed on 7/30/2025, the P&P indicated the following: - The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers such as immobility, recent weight loss, and a history of pressure ulcer(s). - The nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width, and depth, presence of exudates or necrotic tissues. b. Resident's mobility status. c. Current treatments, including support surfaces. d. All active diagnoses. - The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc), and application of topical agents. During a review of the facility's P&P titled, Support Surface Guidelines, last reviewed 7/30/2025, the P&P indicated a purpose to provide guidelines for the assessment of appropriate pressure reducing and relieving devices for residents at risk for skin breakdown. The P&P further indicated: - Individuals at risk for developing pressure ulcers should be placed on a redistribution support surface, such as foam, gel, static air, alternating air, or air loss-gel when lying in bed for residents that recline and depend on staff for repositioning as tolerated. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Care Plans - Baseline, last reviewed 7/30/2024, the P&P indicated a baseline plan of care to meet resident's immediate health and safety needs is developed for each resident within 48 hours of admission. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum information necessary to properly care for the resident including physician orders. 43878 2. During a review of Resident 24's Admission Record, the Admission Record indicated the facility admitted Resident 24 on 9/7/2024 with diagnoses including muscle weakness, pressure ulcer of sacral region (the triangular bone at the base of the spine that connects the spine to the pelvis) stage 4 (the most severe type of bedsore, where the skin damage extends so deep that it exposes underlying muscle, tendon, or bone, often with visible tissue loss and a high risk of infection); pressure ulcer of right buttock, stage 4; and pressure ulcer of right heel stage 1 (a reddened area of skin that doesn't turn white when pressed, indicating potential damage from pressure, but without any open sores or broken skin). During a review of Resident 24's Care Plan created on 7/20/2024, the Care Plan indicated Resident 24 was at risk for skin impairment with interventions that included to administer treatments as ordered and to monitor effectiveness. During a review of Resident 24's Order Summary Report, dated 9/8/2024, the Order Summary Report indicated LALM 1 setting at comfort level 3 or may adjust based on resident's comfort level for wound management, monitor for placement and function every shift. During a review of Resident 24's Care Plan created on 9/8/2024, the Care Plan indicated Resident 24 has a right ischium (a paired bone of the pelvis that forms the lower and back part of the hip bone, as well as the posterior and inferior boundary of the obturator foramen) pressure injury stage 4 with interventions that included LALM for wound management. During a review of Resident 24's MDS dated [DATE], the MDS indicated Resident 24 had the ability to understand and to be understood. The MDS indicated Resident 24 was dependent (helper does all the effort) on toileting, showering, lower body dressing and putting on and taking off footwear and required partial assistance (helper does less than half the effort) with oral hygiene, upper body dressing and personal hygiene. The MDS further indicated Resident 24 had two (2) stage 4 pressure ulcers. During a review of Resident 24's Order Summary Report, dated 1/16/2025, the Order Summary Report indicated: - Right ischium stage 4 injury: cleanses with dakins solution (type of cleansing agent for wounds with anti-infective activity), normal saline (NS - type of cleansing agent for wounds), pat dry, apply therahoney,, calcium alginate (highly absorbent dressing), and cover with foam dressing every day shift. - Sacrococcyx (the fused sacrum and coccyx, or tailbone), stage 4 pressure injury, cleanse with dakins solution, NS, pat dry, apply therahoney, calcium alginate, and cover with foam dressing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 1/18/2025 at 12:10 p.m. observed Resident 24's LALM turned off. During a concurrent observation and interview on 1/18/2025 at 12:12 p.m. with Registered Nurse 3 (RN 3), RN 3 stated Resident 24's LALM was turned off. RN 3 stated all the outlets are taken and the LALM was not plugged in. RN 3 stated not having the LALM turned on can be a risk for Resident 24's wounds to get worse and cause Resident 24 pain. During an interview on 1/22/2025 at 12:47 p.m. with the Director of Nursing (DON), the DON stated LALM is used for residents with skin breakdown or risk for developing pressure ulcers. The DON stated Resident 24 has an order for LALM which should have been turned on. The DON stated if the LALM was not turned on, Resident 24 can be at risk for developing a pressure ulcer and for the pressure ulcers to get worse. During a review of the facility's policy and procedures (P&P) titled, Support Surface Guidelines, last reviewed on 7/30/2024, the P&P indicated redistribution support surfaces are to promote comfort for all bed or chairbound residents, promote circulation and provide pressure relief or reduction. Individuals at risk for developing ulcers should be placed on redistribution support surface, such as foam, gel, static air, alternating air, or air-loss or gel when lying in bed. During a review of LALM 1 Manual with a date of 2024, the Manual indicated pressure redistribution and alternating pressure therapy have been demonstrated to reduce the risk of pressure injuries and as being a valuable aid in the treatment of pressure injuries. In the powered alternating pressure mode, the Pressure Redistribution Optimization (P.R.O) mat plus adds the benefit of cyclic offloading for advance treatment of uncomplicated stage 3 or 4 pressure injuries for resident where such therapy may improve pressure redistribution and circulation. 3. During a review of Resident 26's Admission Record, the Admission Record indicated the facility admitted Resident 26 on 12/6/2023 with diagnoses including muscle weakness (generalized), pressure ulcer of left lower back, and abnormal weight loss. During a review of Resident 26's Care Plan created on 12/20/2023 for Resident 26's risk for unavoidable pressure ulcer, the Care Plan indicated interventions to administer treatment as ordered and monitor for effectiveness. During a review of Resident 26's MDS dated [DATE], the MDS indicated Resident 26 usually understood others and was usually understood. The MDS indicated Resident 26 was dependent on toileting, showering, lower body dressing, and putting on and taking off footwear; and required substantial (helper does more than half the effort) with eating, oral hygiene, upper body dressing, and personal hygiene. During a review of Resident 26's Order Summary Report dated 10/25/2024, the Order Summary Report indicated to provide LALM 1 for wound management. Monitor for proper function and placement every shift. (continued on next page)

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	01/22/2025

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 26's Order Summary Report dated 1/3/2025, the Order Summary Report indicated scarococcyx moisture-associated skin damage (MASD-a general term for inflammation of skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage, saliva or mucus): cleanse with NS, pat dry, apply antifungal, zinc oxide (type of topical treatment) and cover with dry dressing every day shift for 30 days. During an observation on 1/18/2025 at 11:42 a.m., observed Resident 26's LALM was turned off. During a concurrent observation and interview on 11/18/2025 at 11:59 a.m. with RN 3, RN 3 stated Resident 26's LALM should have been turned on. RN 3 stated the LALM for Resident 26 was not plugged in as there were no more electrical outlets. RN 3 stated having LALM turned off can be a potential for Resident 26 to develop a pressure injury and to cause pain and discomfort. During an interview on 1/22/2025 at 12:47 p.m. with the DON, the DON stated LALMs are used for residents with skin breakdown or at risk for developing pressure ulcers. The DON stated Resident 26 has an order for LALM which should have been turned on. The DON stated if the LALM was not turned on, Resident 26 can be at risk to develop a pressure ulcer and/or for the pressure ulcers to get worse. During a review of the facility's policy and procedures (P&P) titled, Support Surface Guidelines, last reviewed on 7/30/2024, the P&P indicated redistribution support surfaces are to promote comfort for all bed or chairbound residents, promote circulation and provide pressure relief or reduction. Individuals at risk for developing ulcers should be placed on redistribution support surface, such as foam, gel, static air, alternating air, or air-loss or gel when lying in bed. During a review of LALM 1 Manual with a date of 2024, the Manual indicated pressure redistribution and alternating pressure therapy have been demonstrated to reduce the risk of pressure injuries and as being a valuable aid in the treatment of pressure injuries. In the powered alternating pressure mode, the Pressure Redistribution Optimization (P.R.O) mat plus adds the benefit of cyclic offloading for advance treatment of uncomplicated stage 3 or 4 pressure injuries for resident where such therapy may improve pressure redistribution and circulation.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on observation, interview, and record review, the facility failed to ensure the resident environment was free of accident hazards for two (2) of eight (8) sampled residents (Residents 38 and 7) investigated under accidents care area by: 1. Failing to ensure there was no furniture or equipment on top of Resident 38's left floor mat. This deficient practice placed the resident at risk for increased chances of incurring injury such as falls with fracture (a break or crack in a bone) and even death. 2. Failing to ensure one and a half pills were not left unattended at Resident 7's bedside accessible and readily available for self-administration by other residents. This deficient practice had the potential to result in residents' self-administration of medication potentially resulting in residents' overdose and illness. Findings: a. During a review of Resident 38's Admission Record, the Admission Record indicated the facility admitted the resident on 12/5/2024, with diagnoses including history of falling, type 2 diabetes mellitus (a chronic disease that occurs when the body does not produce enough insulin or does not use it properly), and generalized weakness. During a review of Resident 38's History and Physical (H&P) dated 12/6/2024, the H&P indicated Resident 38 did not have the capacity to understand and make decisions. During a review of Resident 38's Minimum Data Set (MDS, a resident assessment tool), dated 12/10/2024, the MDS indicated the resident had severely impaired cognition (having the ability to think, learn, and remember clearly). The MDS indicated Resident 38 required supervision or touching assistance with eating; partial/moderate assistance with oral hygiene and personal hygiene; substantial/maximal assistance with mobility and upper body dressing; total assistance with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 38 had a history of fall prior to admission to the facility. During a review of Resident 38's Order Summary Report, the Order Summary Report indicated a physician's order dated 12/11/2024 for bedside padded fall mats. During a review of Resident 38's Fall Risk assessment dated [DATE], the Fall Risk Assessment indicated Resident 38 was a high risk for falls. During a review of Resident 38's care plan (CP) on high risk for unavoidable falls with injury related to limited mobility and gait or balance problems initiated on 12/11/2024, the CP indicated the resident needs a safe environment with even floors free from spills and or clutter as one of the interventions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 1/18/2025 at 10:56 a.m., inside Resident 38's room, observed Resident 38's left floor mat with overbed table on top of the floor mat. During a concurrent observation and interview on 1/18/2025 at 12:20 p.m., inside Resident 38's room with Certified Nursing Assistant 8 (CNA 8) and CNA 12, CNA 8 verified Resident 38's overbed table was placed on top of the left floor mat. CNA 8 stated the overbed table had always been placed on top of the floor as Resident 38 preferred for the table to be placed next to the bed, so the water pitches is within reach. When the table was moved away from the floor mat, CNA 8 verified the table was unstable and almost fell on the floor. CNA 8 stated Resident 38's overbed table should not have been placed on top of the floor mat as the table can be unstable and fall on the resident causing injury. CNA 8 stated Resident 38 can also get injured when she rolls out of the bed and hit the table. During a concurrent observation and interview on 1/19/2025 at 1:50 p.m. inside Resident 38's room with Registered Nurse 1 (RN 1), RN 1 verified Resident 38's over bed table was on top of the left floor mat. RN 1 stated she was not aware if the overbed table can be placed on top of the floor mat. RN 1 stated the overbed table can be unstable and possibly fall on the resident. RN 1 stated the overbed table should not have been left on top of Resident 38's floor mat as it can be unstable and had the potential to fall on the resident and cause injury. RN 1 stated Resident 38 can hit the table in case of a fall incident which may lead to injury. During a review of the facility provided manufacturer's guideline on Floor Mat 1 (FM 1), dated 11/2017, the manufacturer's guideline indicated to check to ensure the bedside matt does not pose a tripping hazard to residents or staff. During a review of the facility's policy and procedure (P&P) titled, Safety and Supervision of Residents, last reviewed 7/30/2024, the P&P indicated: - Individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. - Implementing interventions to reduce accident risks and hazards shall include the following: a. Communicating specific interventions to all relevant staff. b. Ensuring the interventions are implemented c. Documenting interventions - Monitoring the effectiveness of interventions shall include the following: a. Ensuring the interventions are implemented correctly and consistently. - Certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures which include bed safety and falls. 44244 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. During a review of Resident 7's Admission Record, the Admission Record indicated the facility admitted the resident on 3/11/2024 and readmitted the resident on 11/30/2024 with diagnoses that included metabolic encephalopathy (an alteration in consciousness due to brain dysfunction), major depressive disorder (persistent feelings of sadness and loss of interest that can interfere with daily living), difficulty swallowing, and insomnia (inability to sleep). During a review of Resident 7's MDS dated [DATE], the MDS indicated the resident was able to understand others and was able to make herself understood. The MDS further indicated the resident required partial/moderate assistance from staff for personal hygiene and substantial/maximal assistance from staff for toileting, upper body dressing, and mobility. During a review of Resident 7's Care Plan (CP) titled, The resident uses antidepressant medication related to depression, trazodone HCL (a medication to treat insomnia) .at bedtime for depression manifested by inability to sleep, initiated 3/12/2024, the CP indicated to give antidepressant medications ordered by physician and to monitor/document side effects such as nausea, vomiting, anxiety, dizziness, drowsiness, fatigue, and increased risk for falls. During a review of Resident 7's Order Summary Report, the Order Summary Report indicated an order for trazodone HCL oral tablet 50 milligrams (mg, a unit of measurement), give 1.5 tablet by mouth at bedtime for depression manifested by poor sleep / insomnia, dated 12/17/2024. During a review of Resident 7's Admission/Readmission Data Tool, dated 11/30/2024, the Admission/Readmission Data Tool indicated the resident did not want to self-administer medication and a self- administration evaluation was not completed. During a concurrent observation and interview on 1/18/2025 at 9:15 a.m., observed Resident 7 lying on bed sleeping. Observed a clear plastic cup containing one and a half pills on the resident's bedside rolling table. Observed Licensed Vocational Nurse 8 (LVN 8) assisting Resident 7's roommate. LVN 8 stated she had not provided any medications to Resident 7. LVN 8 stated she did not know what type of medication was in the cup or who left the cup with pills at Resident 7's bedside. LVN 8 stated she would remove the medications and report it to the Director of Nursing (DON). LVN 8 exited the room and returned after a short period of time. LVN 8 stated Resident 7 was not safe to self-administer medications because Resident 7 is confused. LVN 8 stated medications should never be left at a resident's bedside because any of the facility residents could get the medication and take it. During a follow- up interview on 1/18/2025 at 4:20 p.m. with LVN 8, LVN 8 stated the medication left at Resident 7's bedside was trazodone. LVN 8 stated Licensed Vocational Nurse 1 (LVN 1) left the medication. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/18/2025 at 6:02 p.m. with LVN 1, LVN 1 stated she cared for Resident 7 the evening of 1/17/2025. LVN 1 stated Resident 7 told her she was not ready to go to sleep yet and asked LVN 1 to leave trazodone on the table for the resident to take later. LVN 1 stated she trusted Resident 7 and left one a half pills of trazodone at the resident's bedside. LVN 1 stated she forgot to go back to check if the resident took the medication because it was one of those nights. LVN 1 stated the correct way to administer medication was to stay with the resident and watch them take the medication, but she did not do that with Resident 7. LVN 1 stated she knew it was not safe to leave trazodone at the resident's bedside because other residents could take the medication, but she trusted the resident. LVN 1 stated it was not safe to leave the trazodone because it may cause an allergic reaction or be life threatening to other residents because it makes people sleepy. During a concurrent interview and record review on 1/20/2025 at 9:07 a.m. with the DON, the DON reviewed the facility policy and procedures regarding self-administration of medications and resident supervision. The DON stated she investigated the medications that were left at Resident 7's bedside. The DON stated LVN 1 stated she left trazodone at the resident's bedside and didn't really give a specific reason why she left the medication. The DON stated medications should never be left at a resident's bedside because it is not safe for the resident or any other resident. The DON stated even if a resident wishes to self-administer medications, it must be under the supervision of a licensed nurse. The DON stated if trazodone is left at a resident's bedside it may be taken at the wrong time or by another resident causing dizziness and potentially resulting in resident falls with injury. The DON stated the facility policy for medication self-administration and resident supervision were not followed when LVN 1 left trazodone at Resident 7's bedside. During a review of the facility policy and procedure (P&P) titled, Self-Administration of Medications, last reviewed 7/30/2024, the P&P indicated residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team (IDT) has determined that the practice would be safe for the resident and other residents of the facility. If a resident indicates no desire to self-administer medications, this is documented in the appropriate place in the resident's medical record, and the resident is deemed to have deferred this right to the facility. Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the rooms of, or room with, residents who self-administer. During a review of the facility P&P titled, Safety and Supervision of Residents, last reviewed 7/30/2024, the P&P indicated the facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Employees are trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision. During a review of the facility policy and procedure (P&P) titled, Medication Administration, last reviewed 7/30/2024 , the P&P indicated Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Medications are administered by the nurse that prepared them. The resident is always observed after administration to ensure that the dose was completely ingested.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. 38552 Based on interview and record review, the facility failed to ensure a resident who received hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) was assessed after dialysis treatment and to document the assessment for one of one sampled resident (Resident 76) investigated during review of dialysis care area. This deficient practice had the potential for unidentified complications such as swelling, pain, bleeding, and bruising and had the potential to result in lack of provision of necessary treatment and services after dialysis treatment. Findings: During a review of Resident 76's Admission Record the facility admitted the resident on 11/7/2024 with diagnoses including end stage renal disease (ESRD -irreversible kidney failure), dependence on renal (kidney) dialysis, and heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 76's Minimum Data Set (MDS, a resident assessment tool), dated 11/22/2024, indicated the resident made self understood and had the ability to understand others. The MDS indicated the resident required total dependence on staff with roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, and chair/bed-to-chair transfer. The MDS indicated Resident 76's hemodialysis was performed while a resident of the facility and within the last 14 days. During a review of Resident 76's Order Summary Report, indicated the following: - Monitor Dialysis site for tenderness, redness or bleeding every shift. Document findings outside of baseline and call the physician every shift, dated 11/17/2024. - Dialysis Schedule: Monday, Wednesday, and Friday Dialysis, chair time 4:15 a.m. and return time 7:30 a.m. , dated 1/5/2025. During a concurrent interview and record review of Resident 76's Dialysis Communication Record and Nursing Progress Notes, on 1/19/2025 at 4:32 p.m., with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated she has seen the Dialysis Communication Record, but she has never filled it out. LVN 4 stated she would document on the nursing progress notes the assessments and time of arrival for residents on dialysis. LVN 3 stated she worked 7 a.m. to 3 p.m. on 1/8/2025 and 1/10/2025 on Resident 76's scheduled dialysis days. LVN 3 stated she did not have any documentation, she does not recall why, and she should have assessed and documented. LVN 3 stated the vital signs written on the Dialysis Communication Record dated 1/8/2025 and 1/10/2025 were not her handwriting. LVN 3 stated cognitive status, access site and central line should be checked, nurse signature, resident return to the facility and date were not filled. LVN 3 stated same on 1/16/25 and 1/17/25 there were no notes of cognitive status, access site, central line location and time back to facility were not filled. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/22/2025 at 1:05 p.m., with the Director of Nursing (DON), the DON stated when the residents finished dialysis there could be side effects tiredness, nausea, initially coming from dialysis and need to make sure they monitor vital signs are stable and the site has no bleeding. The DON stated the residents should be assessed the resident arrives back to the facility. The DON stated the licensed nurses/charge nurses are responsible in completing the dialysis communication record before and after dialysis. The DON stated if it's not in the dialysis communication they may document in the nursing progress notes but their facility utilizes the dialysis communication record forms. The DON stated the purpose of documentation is to show proof that the charge nurses assessed the resident and can refer, if needed. The DON stated if it was not documented it was not done. During a review of the facility's policy and procedure (P&P) titled, Renal Dialysis, Care of Residents, last reviewed 7/30/2024, the P&P indicated that it is the facility's policy to follow standards of care for residents receiving renal dialysis. The P&P indicated the access site care will be provided by a licensed nurse, with physician's order; access site care is checked for condition and patency every shift; and physician/s are notified immediately of any apparent complications. The P&P indicated resident's care documentation including recording of date, time, access site conditions, patency after dialysis and access site care in the Dialysis Communication Form.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring and administering of all drugs and biologicals to meet the needs of each resident: A. During an inspection of two (2) out of two (2) medication carts (Medication Cart 1 [[MC 1 and MC 2]) under the Medication Storage and Labeling Task by: 1. Failing to ensure Licensed Vocational Nurse 2 (LVN 2) and Licensed Vocational Nurse 5 (LVN 5) administer Resident 22's 5 p.m. dose of apixaban (an anticoagulant medication used to treat and prevent blood clots and to prevent stroke in people with atrial fibrillation [A-fib - an irregular and often very rapid heart rhythm]), metformin (a medication used to treat high blood sugar levels that are caused by type 2 diabetes mellitus [DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing]), and Coreg (a medication used to treat high blood pressure) on 1/3/2025 and 1/14/2025. 2. Failing to ensure LVN 5 administer Resident 82's bedtime (HS) dose of donepezil (a medication used to treat dementia by improved attention, memory and ability to complete daily tasks) on 1/1/2025 and 1/14/2025 and atorvastatin (a medication used to lower cholesterol and fat level to help prevent chest pain, stroke [a loss of blood flow to a part of the brain], and heart disorders) on 1/14/2025. These deficient practices placed Residents 22 and 82 at risk for complications and delay in the necessary care and services needed related to not receiving medications as prescribed by the physician such increase in blood pressure, increase in blood sugar, formation of blood clots which may lead to stroke. 3. Failing to safely and properly store medications for MC 2 when expired medication was stored in MC 2. This deficient practice had the potential for residents to consume expired medications. 4. Failing to ensure LVN 1 documented in the Resident 45's medication administration record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) that one (1) tablet of hydrocodone acetaminophen (Norco - a combination drug used to relieve pain severe enough to require opioid [a class of medication used to treat used to treat moderate to severe pain but can also be addictive] treatment) 5-325 milligrams (mg - a unit of measurement) was administered on 1/12/2025 at 5:00 p.m. This deficient practice had the potential for inaccurate reconciliation of controlled medication and placed the facility at potential for inability to readily identify loss and drug diversion (illegal distribution of prescription drugs for their use for unintended purposes) of controlled medications and resulted in the resident not receiving their prescribed medication. (continued on next page)

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	055287	A. Building B. Wing	01/22/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. By failing to ensure Licensed Vocational Nurse 1 (LVN 1) checked the resident's heart rate (HR, the number of times the heart beats per minute [bpm]) prior to administering metoprolol (a medication to treat high blood pressure [BP, the force of the blood pushing on the blood vessel walls]) with a physician's ordered parameter (a set of defined limits) to hold (do not give) if the HR was less than 60 bpm for one of seven sampled residents (Resident 62) reviewed during the Medication Administration task. This deficient practice had the potential to cause complications such as irregular or low heart rate or injury to the heart resulting in hospitalization . C. Failing to ensure the oral medication emergency kit (PO e-kit - a small quantity of medications that can be dispensed when pharmacy services are not available) was replaced within 72 hours according to the facility's policy and procedure in one of one medication rooms (Station A Med Room) reviewed during the Medication Storage task. This deficient practice had the potential to result in delayed or inadequate response to emergency situations, potentially leading to worsened outcomes for residents. Findings: a. During a review of Resident 22's Admission Record, the Admission Record indicated the facility originally admitted the resident on 5/6/2013 and readmitted in the facility on 3/18/2022 with diagnoses including DM 2, hypertension (HTN - high or raised blood pressure, a condition in which the blood vessels have persistently raised pressure), and atrial fibrillation. During a review of Resident 22's History and Physical (H&P) dated 11/30/2024, the H&P did not indicate Resident 22's capacity to understand and make decisions. During a review of Resident 22's Minimum Data Set (MDS, a resident assessment tool), dated 10/21/2024, the MDS indicated the resident had severely impaired cognition (having the ability to think, learn, and remember clearly). The MDS indicated Resident 22 required supervision or touching assistance with eating; substantial/maximal assistance with bed mobility; total assistance with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 22 received an anticoagulant (a blood-thinning medication used to prevent and treat blood clots in blood vessels and the heart to reduce the risk of having a stroke) medication. During a review of Resident 22's Order Summary Report, the Order Summary Report indicated the following physician's orders: - 10/29/2022: Coreg (carvedilol) 3.125 milligrams (mg - a unit of measurement) give one (1) tablet by mouth two (2) times a day related to HTN hold for systolic blood pressure (SBP - the top number measures the force the heart exerts on the walls of the arteries each time it beats) less than 110 millimeters of mercury (mmHg-a unit of measurement) or heart rate (HR) less than 60. Administer with food. - 3/18/202: Eliquis tablet five (5) mg (apixaban) give 1 tablet by mouth 2 times a day for A-fib) (continued on next page)

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	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 4/21/2022: Metformin hydrochloride 1000 mg give 1000 mg by mouth 2 times a day related to DM 2. Give with food. During a review of Resident 22's MAR for January 2025, the MAR indicated Resident 22 SBP and HR on 1/13/2025 and 1/14/2025 were as follows and were marked with a check and licensed nurses' initials: - 1/13/2025: BP 133/66; HR 77 - 1/14/2024: BP: 126/72; HR 72 During an inspection of MC 1 on 1/19/2025 at 10:50 a.m. and concurrent interview and record review, reviewed Resident 22's 5 p.m. blister packs (a card that packages doses of medication within small, clear, or light-resistant, amber-colored plastic bubbles [or blisters]) and Medication Administration Record (MAR) with Licensed Vocational Nurse 8 (LVN 8). LVN 8 verified Resident 22's 5:00 p.m. doses of Eliquis, Coreg, and metformin for 1/13/2025 and 1/14/2025 were administered as indicated by a check mark in the MAR but remained in the blister pack. LVN 8 verified the MAR indicated Resident 22's SBP on 1/13/2025 was 133 millimeters of mercury (mmHg - a unit of measurement) and 127 mm Hg on 1/14/2024; HR was 77 on 1/13/2025 and 72 on 1/14/2025. LVN 8 stated the new medication cycle for all their long-term residents start on the first day of each month and nurses are supposed to start removing medications on the number 1 slot. LVN 8 stated the MAR indicated the licensed nurses who worked on 1/13/2025 and 1/14/2025 were LVN 2 and LVN 5. LVN 8 stated if the medications remained in the blister pack, the medications were not given and placed the residents at risk of complications such as high blood sugar and high blood pressure. LVN 8 stated in administering medications, licensed nurses are supposed to administer the medication first prior to signing the MAR. During an interview on 1/19/2025 at 4:12 p.m. with Licensed Vocational Nurse 2 (LVN 2), LVN 2 verified she worked on 1/13/2025 and 1/14/2025 during the 3 p.m. to 11 p.m. shift. LVN 2 stated she was made aware that Resident 22's 5 pm dose of Coreg, Eliquis, and metformin remained in the blister pack for 1/13/2025 and 1/14/2025. LVN 2 stated during administration of medications, the nurses compare the blister pack with the physician's order for accuracy and remove the medications from the blister pack, check the vital signs, and administer the medications according to the parameter and sign the MAR after the medications were administered. LVN 2 stated the check mark indicated the scheduled medications were administered. LVN 2 stated she should not have signed the MAR if the medications were not administered. LVN 2 stated she should have administered Resident 22's medications as ordered by physician. LVN 2 stated if the medications were not administered, it placed Resident 22 at risk for complications such as high blood pressure, high blood sugar, and blood clots. During an interview on 1/20/2025 at 8:24 a.m. with Licensed Vocational Nurse 5 (LVN 5), LVN 5 verified that he worked on 1/13/2025 and 1/14/2025 3 p.m. to 11 p.m. shift. LVN 5 stated cycle medication blister packs for all residents start on the first day of each month and nurses are supposed to remove number 1 slot. LVN 5 stated during medication administration, the blister pack should be compared with the MAR and the physician's order to ensure that they are all matching and accurate then remove the corresponding day. LVN 5 stated he was made aware that the 5 p.m. doses of Resident 22's Eliquis, Coreg, and metformin remained in the blister pack for 1/13/2025 and 1/14/2025. LVN 5 stated if the medications remained in the blister pack, he did not administer the medications and was unable to remember why the medications were not given. LVN 5 stated he should have administered the medications as ordered by the physician as it placed Resident 22 at risk for increase in blood sugar, blood pressure, and increased risk for blood clots. (continued on next page)

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	01/22/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/20/2025 at 8:34 a.m., with Registered Nurse 1 (RN 1), RN 1 stated during medication administration, the blister packs are compared the MAR, and physician's order to ensure accuracy and no discrepancy. RN 1 stated cycle medication blister packs for all residents start every first day of the month and licensed nurses are supposed to remove the medications starting from number 1 slot and the corresponding date of the month thereafter. RN 1 stated if a medication remained on the blister pack, the medication was not administered if the vital signs parameters were met. RN 1 stated is a dose was not administered, the licensed nurses are supposed to indicate the reason for not administering the medication according to the code found at the bottom of the MAR. RN 1 stated LVN 2 and LVN 5 should have administered Resident 22's 5:00 p.m. medications as ordered by the physician as it placed Resident 22 at risk for complications such as increase in blood sugar, blood pressure, increased risk of blood clots which may lead to stroke. During a review of the facility's policy and procedure (P&P) titled, Medication Administration - General Guidelines, last reviewed 7/30/2024, the P&P indicated medications are administered as prescribed in accordance with good nursing principles and practices. The P&P further indicated: - Medications are administered at the time they are prepared. - The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented - If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled times, the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided. Documentation procedures may be revised based on the electronic MAR protocol. b. During a review of Resident 82's Admission Record, the Admission Record indicated the facility admitted the resident on 9/20/2024 with diagnoses including dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness, and loss of interest), and generalized weakness. During a review of Resident 82's H &P dated 11/30/2024, the H&P did not indicate Resident 82's capacity to understand and make decisions. During a review of Resident 82's MDS dated [DATE], the MDS indicated the resident had moderately impaired cognition (having the ability to think, learn, and remember clearly). The MDS indicated Resident 82 required set-up or clean-up assistance with eating and oral hygiene; partial/moderate assistance with shower transfers; supervision or touching assistance with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 82's Order Summary Report, the Order Summary Report indicated the following physician's orders: - 9/20/2024: atorvastatin hydrochloride oral tablet 40 mg give 1 tablet by mouth at bedtime for hyperlipidemia (a condition where there is too much fat in the blood). (continued on next page)

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	01/22/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 9/20/2024: donepezil hydrochloride oral tablet 10 mg give 1 tablet by mouth at bedtime for dementia. During a review of Resident 82's MAR for 1/2025, the MAR indicated the HS dose of Resident 82's atorvastatin and donepezil were marked with a check and licensed nurses' initials. During an inspection of MC 1 on 1/19/2025 at 10:50 a.m. and concurrent interview and record review with Licensed Vocational Nurse 8 (LVN 8), blister packs (a card that packages doses of medication within small, clear, or light-resistant, amber-colored plastic bubbles [or blisters]) and Medication Administration Record (MAR) with Licensed Vocational Nurse 8 (LVN 8). LVN 8 verified Resident 82's HS dose of atorvastatin for 1/14/2025 and donepezil for 1/1/2025 and 1/14/2025 were administered as indicated by a check mark in the MAR but remained in the blister pack. LVN 8 stated the new medication cycle for all their long-term residents start on the first day of each month and nurses are supposed to start removing medications on the number 1 slot. LVN 8 stated the MAR indicated the licensed nurse who worked on 1/13/2025 and 1/14/2025 was LVN 2. LVN 8 stated if the medications remained in the blister pack, the medications were not given and placed the residents at risk of possible progression of dementia and increased fats in the blood. LVN 8 stated in administering medications, licensed nurses are supposed to administer the medication first prior to signing the MAR. During an interview on 1/19/2025 at 4:12 p.m. with Licensed Vocational Nurse 2 (LVN 2), LVN 2 verified she worked on 1/1/2025 and 1/14/2025 during the 3 p.m. to 11 p.m. shift. LVN 2 stated she was made aware that Resident 82's HS dose of atorvastatin for 1/14/2025 and donepezil for 1/1/2025 and 1/14/2025 remained in the blister pack. LVN 2 stated during administration of medications, the nurses compare the blister pack with the physician's order for accuracy and remove the medications from the blister pack, check the vital signs, and administer the medications according to the parameter and sign the MAR after the medications were administered. LVN 2 stated the check mark in the MAR indicated the scheduled medications were administered. LVN 2 stated she should not have signed Resident 82's MAR if the medications were not administered. LVN 2 stated she should have administered Resident 82's medications as ordered by physician. LVN 2 stated if the medications were not administered, it placed Resident 82 at risk for complications such as possible progression of dementia and increased level of fats in the blood. During an interview on 1/20/2025 at 8:34 a.m., with Registered Nurse 1 (RN 1), RN 1 stated during medication administration, the blister packs are compared the MAR, and physician's order to ensure accuracy and no discrepancy. RN 1 stated cycle medication blister packs for all residents start every first day of the month and licensed nurses are supposed to remove the medications starting from number 1 slot and the corresponding date of the month thereafter. RN 1 stated if a medication remained on the blister pack, the medication was not administered if the vital signs parameters were met. RN 1 stated if a dose was not administered, the licensed nurses are supposed to indicate the reason for not administering the medication according to the code located at the bottom of the MAR. RN 1 stated LVN 2 should have administered Resident 82's HS medications as ordered by the physician as it placed Resident 82 at risk for complications such as possible progression or worsening of dementia and increased risk of worsening hyperlipidemia. During a review of the facility's policy and procedure (P&P) titled, Medication Administration - General Guidelines, last reviewed 7/30/2024, the P&P indicated medications are administered as prescribed in accordance with good nursing principles and practices. The P&P further indicated: (continued on next page)

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	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Medications are administered at the time they are prepared. - The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented - If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled times, the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided. Documentation procedures may be revised based on the electronic MAR protocol. c. During a review of Resident 45's Admission Record, the Admission Record indicated the facility originally admitted the resident on 11/13/2024 and readmitted in the facility on 12/23/2024 with diagnoses including multiple sclerosis (a long-lasting condition that causes breakdown of the protective covering of nerves [a bundle of fibers that receives and sends messages between the body and the brain]) which can cause numbness, weakness, trouble walking, and vision changes) difficulty in walking, and generalized weakness. During a review of Resident 45's H&P dated 11/15/2024, the H&P indicated Resident 45 had the capacity to understand and make decisions. During a review of Resident 45's MDS dated [DATE], the MDS indicated the resident was able to understand others and make his needs known and had an intact cognition (having the ability to think, learn, and remember clearly). The MDS indicated Resident 45 was independent with eating; supervision with oral hygiene; partial/moderate assistance with bed mobility, upper body dressing, and personal hygiene; shower transfers; substantial/maximal assistance with toileting, chair/bed transfers, and sit to stand; total assistance with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 45 received opioids (a class of medication used to treat used to treat moderate to severe pain but can also be addictive). During a review of Resident 45's Order Summary Report, the Order Summary Report indicated a physician's order dated 1/11/2025 with a discontinue date of 1/25/2025: - Norco oral tablet 5-325 mg (hydrocodone-acetaminophen) give 1 tablet by mouth every 4 hours as needed for pain rate seven (7) out of then (10) for 14 days not to exceed 3 grams (gm - a unit of measurement) acetaminophen in 24 hours. Do not give if respiratory rate (RR) is less than 12 or drowsy then notify physician. (continued on next page)

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	01/22/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an inspection of MC 1 on 1/19/2025 at 10:50 a.m. and concurrent interview and record review with Licensed Vocational Nurse 8 (LVN 8), reviewed Resident 45's blister pack (a card that packages doses of medication within small, clear, or light-resistant, amber-colored plastic bubbles [or blisters]) for Norco, Antibiotic or Controlled Drug Record (ACDR - a log signed by the licensed nurses with the date and time each time a controlled substance is given to a resident) for Norco, and Medication Administration Record (MAR) with Licensed Vocational Nurse 8 (LVN 8). LVN 8 stated the ACDR, and the blister pack indicated six (6) tablets were remaining, however Resident 45's MAR did not indicate the resident received the medication 1/13/2025 at 5:00 p.m. LVN 8 verified Resident 45's ACDR indicated the Norco was removed on 11/12/2025 at 5:00 p.m. LVN 8 stated when administering controlled drugs, the physician's order should be checked first and compare the medication label with the order and the MAR. LVN 8 stated once confirmed, may remove the medication from the blister pack , sign the medication out on the ACDR, administer the medication to the resident, and then sign the MAR as administered. LVN 8 stated if the ACDR, blister pack, and MAR do not match, it had the potential for diversion of medications as the staff do not know if the medication was given or not and the resident can receive too much or too little medications resulting to complications. During a concurrent interview and record review on 1/19/2025 at 12:26 p.m., reviewed Resident 45's ACDR and MAR with Licensed Vocational Nurse 1 (LVN 1) verified that she signed out Resident 45's Norco in the ACDR but failed to document the medication was administered to the resident on 1/12/2025 at 5:00 p.m., LVN 1 stated she was distracted by other tasks, and she just wrote down the time of administration but forgot to sign the MAR. LVN 1 stated the policy is to sign the MAR as soon as the medications were administered so the other licensed nurses would be aware of when the last time Resident 45 received the medication as the resident can receive too much of the medication which could cause complications possible resulting in hospitalization . During an interview on 1/20/2025 at 8:34 a.m., with Registered Nurse 1 (RN 1), RN 1 stated during administration of controlled substances, the blister packs are compared the MAR, physician's order, and ACDR to ensure accuracy and no discrepancy. RN 1 stated when administering controlled substances, the licensed nurse should enter immediately in the MAR and ACDR the dose, date and time, initials of the nurse in the MAR, and signature of the nurse in the ACDR. RN 1 stated LVN 2 should have signed the MAR immediately the Norco was administered to Resident 45 so the other licensed nurses would be aware of when was the last administration of controlled substance to prevent Resident 45 of getting much of the medication which may lead to complication requiring hospitalization . RN 1 stated not signing the MAR also had the potential for theft/loss or diversion of the controlled substance. During a review of the facility's policy and procedure (P&P) titled, Medication Administration - General Guidelines,' last reviewed 7/30/2024, the P&P indicated medications are administered as prescribed in accordance with good nursing principles and practices. The P&P further indicated: - Medications are administered at the time they are prepared. - The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented (continued on next page)

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	01/22/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled times, the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided. Documentation procedures may be revised based on the electronic MAR protocol. During a review of the facility's P&P titled, Controlled Medications, last reviewed 7/30/2024, the P&P indicated medications included in the controlled substances are subject to special handling, storage, disposal, and record keeping in the facility in accordance with the federal and state laws and regulations. The P&P further indicated: - When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the MAR: 1. Date and time of administration 2. Amount administered 3. Signature of the nurse administering the dose on the accountability record at the time the medication is removed from the supply 4. Initials of the nurse administering the dose on the MAR after the medication is administered. 44244 d. During a review of Resident 62's Admission Record, the Admission Record indicated the facility admitted the resident on 6/30/2022 and readmitted the resident on 12/19/2024 with diagnoses that included essential (primary) hypertension (high blood pressure with an unknown cause), aphasia (a disorder that makes it difficult to speak) following cerebral infarction (CVA-stroke, loss of blood flow to a part of the brain), and angina pectoris (chest pain or discomfort that occurs when the heart muscle doesn't receive enough oxygen). During a review of Resident 62's MDS dated [DATE], the MDS indicated the resident usually was able to understand others and was sometimes able to make himself understood. The MDS further indicated the resident required partial/moderate assistance from staff for oral hygiene, lower body dressing, toileting, and bathing. During a review of Resident 62's Order Summary Report, the report indicated an order for metoprolol tartrate oral tablet, give 50 milligrams (mg, a unit of measurement) by mouth two times a day for HTN, hold for systolic blood pressure (SBP - the pressure in your arteries [pathway that carries blood away from the heart] when your heart beats) less than 110 millimeters of mercury (mmHg-a unit of measure) or HR less than 60 bpm; give with food, dated 12/21/2024. (continued on next page)

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	055287	A. Building B. Wing	01/22/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a medication administration observation on 1/18/2025 at 5:45 p.m., with LVN 1 at the Station A Medication Cart, LVN 1 prepared Resident 62's medications. LVN 1 stated she needed to check the residents BP before giving his medication. LVN 1 entered the resident's room and manually checked Resident 62's BP. LVN 1 stated the resident's SBP was 122 and she would give the medication. LVN 1 administered Resident 62's metoprolol. LVN 1 exited Resident 62's room to document the administration of the metoprolol in the Medication Administration Record and stated she forgot to check the resident's HR prior to administering the metoprolol. LVN 1 reentered Resident 62's room, checked the residents HR, and stated the HR was 65 bpm. LVN 1 exited the resident's room and stated she should have checked the resident's HR prior to giving the medication, but she did not because she was nervous. LVN 1 stated it was important to check the resident's HR prior to administering metoprolol because if the HR was below 60 bpm she should not give the medication per the physician's order. LVN 1 stated if metoprolol is giving with too low of a HR, it may cause the resident to become dizzy or fall. During a concurrent interview and record review on 1/20/2025 at 9:07 a.m., with the Director of Nursing (DON), the DON reviewed the facility policy and procedures regarding medication administration. The DON stated metoprolol is a medication that has a hold parameter for the HR. The DON stated the HR must be checked prior to administering the medication to know if the medication should not be administered. The DON stated it was important to not administer metoprolol if the HR was too low because it may further drop the resident's HR potentially leading to a loss of consciousness or cardiac issues. The DON stated when LVN 1 gave Resident 62 the metoprolol without first checking his HR, it was a medication error and the facility policy was not followed. During a review of the facility policy and procedure (P&P) titled, Medication Administration, last reviewed 7/30/2024 , the P&P indicated Medications are administered as prescribed in accordance with good nursing principles an practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with he medication. Medications are administered in accordance with written orders of the attending physician. e. During a medication storage observation on 1/19/2025 at 10:32 a.m. in the Station A Med Room with Licensed Vocational Nurse 9 (LVN 9) and the Assistant Director of Nursing (ADON), LVN 9 stated the facility stores e-kits in a locked cabinet to ensure there is a supply of medications in case of an emergency. LVN 9 stated when an e-kit is opened the medication is removed, the date and time and medication removed is written on the log inside the e-kit, the e-kit is closed with yellow zip ties, and the pharmacy is notified to replace the e-kit. Observed a PO e-kit with yellow zip ties. LVN 9 stated the PO e-kit had been opened and multiple medications had been removed. LVN 9 stated the pharmacy usually comes right away to replace the e-kit, but it depends on when the pharmacy was called. The ADON reviewed the PO e-kit's Emergency Kit Pharmacy Log and noted on 1/13/2025 at 9 p.m., two tramadol (a medication to treat pain) 50 mg tablets were removed from the PO e-kit. The ADON stated the e-kit should have been replaced within 72 hours of opening, but it was not. During an interview on 1/19/2025 at 10:51 a.m. with Registered Nurse 1 (RN 1) stated when an e-kit is opened the staff must call the pharmacy to get authorization to open the e-kit. RN-1 stated the pharmacy is notified at that time that the e-kit will be opened and thus the pharmacy knows the e-kit needs to be replaced. RN 1 stated the pharmacy should replace the e-kit within 72 hours of opening. RN 1 stated it was important to ensure the e-kit is replaced within 72 hours to ensure there are emergency medications for residents. (continued on next page)

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	01/22/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/20/2025 at 9:07 a.m. with the DON, the DON reviewed the facility policy and procedure regarding acquiring medications from the pharmacy. The DON stated she investigated why the Station 1 PO e-kit was not replaced within 72 hours per facility policy. The DON stated the facility staff did not understand that calling the pharmacy to request to open the e-kit was not also a request to replace the e-kit. The DON stated a separate phone call must be made to pharmacy to request to replace the e-kit and that phone call was not made for the Station A PO e-kit which resulted in the PO e-kit not being replaced. The DON stated the facility policy was not followed. During a review of the facility P&P titled, Medication Ordering and Receiving from Pharmacy, last reviewed 7/30/2024, the P&P indicated emergency pharmacy service is available on a 24 hour basis. Emergency needs for medication are met by using the facility's approved emergency medication supply. Pharmacy will be called for Pharmacist authorization prior to opening the emergency supply for all controlled substances. As soon as possible, the nurse records the medication use on the medication order form and notifies the pharmacy for replacement of the emergency drug supply. The used sealed kits are replaced with the new sealed kit within 72 hours of opening. 43878 f. During a concurrent observation of the medication storage (MC 2) and interview with Licensed Vocational Nurse 7 (LVN) on 1/20/2025 at 10:18 a.m., observed: - Zinc Sulfate 220 milligrams (mg- a unit of measurement) with an expiration date of 8/2024. - Liquid Pain Relief Acetaminophen 160 mg/ 5 milliliters (ml- unit of measurement) with an expiration date of 7/2024. - Two (2) ensure plus (ready-to-drink, oral nutritional supplement formulated specifically for older adults who have, or are at risk of, malnutrition) 237 ml with an expiration date of 10/10/2024. LVN 7 stated those medications were expired and should have been discarded upon expiration date. LVN 7 stated having expired medication in medication cart is a risk for residents to consume if the nurse does not see the expiration date. LVN 7 stated if a

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	01/22/2025

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 43878 Based on observation, interview, and record review, the facility failed to properly label the open date of Senna (a natural laxative that comes from the leaves and fruit of the senna plant) for one of two Medication Carts (Medication Cart 2 [MC 2]). This deficient practice had the potential for the medication to be ineffective. Findings: During a concurrent observation and interview during a review of the medication storage on 1/20/2025 at 10:18 a.m. with Licensed Vocational Nurse 7 (LVN), MC 2 was observed with Senna 8.6 mg with expiration date of 9/2027 with no open date observed. LVN 7 stated opened Senna container today and did not label it with an open date. LVN 7 stated must put open date on medications so that the facility knows when the medication was opened. During an interview on 1/22/2025 at 12:54 p.m., the Director of Nursing (DON) stated over the counter medication should have an open date. The DON stated medications should have open date because we should not follow expiration date, medications should be discarded three months after opening. During a review of the facility's Policy and Procedures (P&P) titled, Medication Storage in the Facility, last reviewed on 7/30/2024, the P&P indicated medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists. During a review of the facility's P&P titled, Medication ordering and receiving from Pharmacy, last reviewed on 7/30/2024, the P&P indicated floor stock medications are labeled as floor stock or house supply and kept in the original manufacturer's container. The manufacturers or pharmacy's label should include the following: 6. expiration date.

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	055287	A. Building B. Wing	01/22/2025

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 43878 Based on observation, interview, and record review, the facility failed to follow the menu for 88 of 92 residents when on 1/19/2025 [NAME] 1 did not prepare the breakfast omelet and used scrambled eggs for 88 residents for breakfast. This deficient practice had the potential to result in an increased food and nutrient intake resulting in unintended (not done on purpose) weight gain. Cross Reference F804 Findings: During a concurrent observation and interview on 1/19/2025 at 5:40 a.m., [NAME] 1 stated the menu for breakfast has oatmeal and for the puree diet it has cream of wheat, has muffins, toast, and scrambled eggs along with bacon, and sausage. During an interview on 1/19/2025 at 6:12 a.m., [NAME] 1 stated she made a mistake by making scrambled eggs instead of the breakfast omelet that are on the menu for today (1/19/2025). During an interview on 1/19/2025 at 7:53 a.m., the Dietary Supervisor (DS) stated [NAME] 1 made scrambled eggs instead of the omelet that was on the menu. The DS stated it would affect the taste and texture because the scrambled eggs and breakfast omelet are two different foods. During a review of the Policies and Procedures (P&P) titled, Menus, last reviewed on 7/30/2024, the P&P indicated menus are developed and prepared to meet resident choice including religious, cultural, and ethnic needs while following established national guidelines for nutritional adequacy. 1. Menus meet the nutritional needs of residents in accordance with the recommended dietary allowance of the Food and Nutrition Board (National Research Council and National Academy of Sciences). 2. Menus for regular and therapeutic diets are written at least two (2) weeks in advance and are dated and posted in the kitchen at least one (1) week in advance. During a review of the facility's cook's spreadsheet titled, Cycle 4 2024, Week 2 Sunday, dated 1/19/2025, the spreadsheet indicated residents on regular diet would include the following foods in the tray: - Apple Juice four (4) ounces (oz- a unit of measurement) - Hot or cold cereal one (1) serving. - Breakfast omelet one (1) square. - Bacon one (1) slice (continued on next page)

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	01/22/2025

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Muffin one (1) each - Coffee 8 oz - Milk 2% 8 oz During a review of the facility's recipe titled, Breakfast (BRK) Omelet, with a date of 2024, the recipe indicated, ingredients: margarine, all-purposed flour, salt, black pepper, low fat milk (contains lower calories and fat), and liquid eggs. During a review of the facility's recipe titled, Scrambled Egg, with no date, the recipe indicated, ingredients: liquid eggs, whole milk (contains more calories and fat), salt, margarine, and black pepper.

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	055287	A. Building B. Wing	01/22/2025

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 43878 Based on observation, interview, and record review, the facility failed to follow the menu and did not meet nutritional needs for 88 out of 92 residents when on 1/19/2025 [NAME] 1 did not prepare the breakfast omelet and used scrambled eggs for 88 residents for breakfast. This failure had a potential to result in 88 the facility residents to be at risk for unplanned (not done on purpose) weight gain. Cross Reference F803 Findings: During a concurrent observation and interview on 1/19/2025 at 5:40 a.m., [NAME] 1 stated the menu for breakfast has oatmeal and for the puree diet it has cream of wheat, has muffins, toast, and scrambled eggs along with bacon, and sausage. During an interview on 1/19/2025 at 6:12 a.m., [NAME] 1 stated she made a mistake by making scrambled eggs instead of the breakfast omelet that are on the menu for today (1/19/2025). During an interview on 1/19/2025 at 7:53 a.m., the Dietary Supervisor (DS) stated [NAME] 1 made scrambled eggs instead of the omelet that was on the menu. The DS stated it would affect the taste and texture because the scrambled eggs and breakfast omelet are two different foods. During a review of the Policies and Procedures (P&P) titled, Menus, last reviewed on 7/30/2024, the P&P indicated menus are developed and prepared to meet resident choice including religious, cultural, and ethnic needs while following established national guidelines for nutritional adequacy. 1. Menus meet the nutritional needs of residents in accordance with the recommended dietary allowance of the Food and Nutrition Board (National Research Council and National Academy of Sciences). 2. Menus for regular and therapeutic diets are written at least two (2) weeks in advance and are dated and posted in the kitchen at least one (1) week in advance. During a review of the facility's cook's spreadsheet titled, Cycle 4 2024, Week 2 Sunday, dated 1/19/2025, the spreadsheet indicated residents on regular diet would include the following foods in the tray: - Apple Juice four (4) ounces (oz- a unit of measurement) - Hot or cold cereal one (1) serving. - Breakfast omelet one (1) square. - Bacon one (1) slice (continued on next page)

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	055287	A. Building B. Wing	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Muffin one (1) each - Coffee 8 oz - Milk 2% 8 oz During a review of the facility's recipe titled, Breakfast (BRK) Omelet, with a date of 2024, the recipe indicated, ingredients: margarine, all-purposed flour, salt, black pepper, low fat milk (contains lower calories and fat), and liquid eggs. During a review of the facility's recipe titled, Scrambled Egg, with no date, the recipe indicated, ingredients: liquid eggs, whole milk (contains more calories and fat), salt, margarine, and black pepper.

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	055287	A. Building B. Wing	01/22/2025

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 43988 Based on observation, interview, and record review, the facility failed to prepare food in a form designed to meet individual needs (requirements that a person has in order to be well such as food) for one of one sampled resident (Resident 1) on puree diet (a texture modified diet that consists of smooth foods with pudding-like consistency that are easy to swallow) by not following the recipes for puree bread and in accordance with the International Dysphagia Diet Initiative (IDDSI - a framework for categorizing food textures and drink thickness) Level Four (4) Standards (puree foods and extremely thick drinks). On 1/19/2025, Resident 1 was served puree bread that was too sticky and did not fall during the spoon tilt test (a method used to determine the stickiness of food and ability of the food to hold together) at lunch. This deficient practice had the potential to cause Resident 1 to not be able to eat the food, choke (when food gets stuck in your airway, blocking the flow of air to your lungs), and aspirate (when food or liquid enters your airway and lungs instead of your stomach) on the food. On 1/20/2025 at 9:26 p.m., while onsite at the facility, the State Survey Agency (SSA) called an Immediate Jeopardy (IJ - a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death to a resident) under 42 CFR S483.60 Food and Nutrition Services in the presence of the Administrator (ADM) and the Director of Nursing (DON) due to the facility's failure to ensure that facility staff followed the recipe for puree diet and served puree bread that was not too sticky and should have passed the spoon tilt test prior to serving to Resident 1 . On 1/22/2025 at 12:48 p.m., the ADM provided an IJ Removal Plan (a plan that identifies all actions the facility will take to immediately address the noncompliance that has resulted to the IJ situation) which included the following summarized actions: 1. On 1/21/2025, the DON and the Assistant Director of Nursing (ADON) assessed Resident 1 for any signs and symptoms of aspiration (happens when food, liquid, or other material enters a person's airway and eventually the lungs), such as coughing and flushing (a sudden reddening of the face, neck, or upper chest due to increased blood flow) and there were no issues found. A change of condition (when there is a sudden change in a resident's condition) assessment was initiated, and care plan was developed. Resident 1's physician was notified with no further orders. 2. [NAME] 1 was taken off schedule on 1/21/2025 and was provided an in-service (staff training) by the Dietary Supervisor (DS) on 1/22/2025 prior to the next meal service (breakfast) through a return demonstration (a teaching method where a staff practices a skill after an instructor demonstrates it). 3. On 1/21/2025, the Registered Dietitian (RD) provided an in-service to the DS, the DON, the Director of Staff Development (DSD), and the ADM on checking for IDDSI Puree Level 4 consistency using spoon tilt test and fork drip test (a test used to check the correct thickness and cohesiveness of food) and the IDDSI guidelines. The RD validated the in-service through return demonstrations, and they were deemed competent (able to perform tasks successfully) by the RD. (continued on next page)

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	055287	A. Building B. Wing	01/22/2025

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. On 1/21/2025, the RD initiated in-service training to two cooks (Cook 2 and [NAME] 3) and six dietary aides (DAs [DA 1, DA 3, DA 4, DA 5, DA 6, DA 7]) regarding puree food preparation. The RD validated skills check (a list that detail employee skills they are required to perform and the level of performance that is expected for each skill) through question and answer (Q&A) and they (Cook 2, [NAME] 3, DA 1, DA 3, DA 4, DA 5, DA 6, DA 7) were deemed competent. 5. On 1/21/2025, the Speech Language Pathologist (SLP - a health professional who evaluates and treats speech, language, and swallowing disorders) completed the screening of all residents on puree diets and made no new recommendations. No other residents were affected by the deficient practice. 6. On 1/21/2025, the licensed nurses inspected the breakfast meal trays and cross checked with the physician orders. No other residents were affected by the deficient practice. 7. On 1/21/2025, the RD observed the puree food preparation for breakfast, particularly the food preparation for puree pancakes. The RD validated that the puree pancakes had the right consistency using the IDDSI framework utilizing the spoon tilt test. No other residents were affected by the deficient practice. 8. Beginning 1/22/2025, the RD, the DS, the Manager of the Day (MOD), and/or Registered Nurse (RN) Supervisor started conducting a puree food consistency test using the spoon tilt test methods for all meals including snacks every day, including weekends and holiday for 90 days. The Spoon-Tilt form will be utilized, and any identified issues will be reported to the RD and/or designee for further follow-up and correction through a group chat. The schedule for spoon tilt test is as follows: - Breakfast: 11 p.m. to 7 a.m. shift RN Supervisor or Charge Nurse Cart 1 - Lunch: the RD, the DS, the MOD and/or designee - Snack: 3 p.m. to 11 p.m. RN Supervisor or Charge Nurse Cart 2 - Dinner: 5 p.m. spoon tilt tests to be performed by a variety of staff. For example, the current schedule as follows: Sunday, the Activities Department Staff; Monday, the Infection Preventionist Nurse (IPN); Tuesday, the ADM; Wednesday, the DON; Thursday, the Medical Records Assistant; Friday, the DSD Assistant. 9. Beginning 1/21/2025, the RD and the DS initiated in-service training to cooks and dietary aides regarding: (1) Daily Menu Guide, (2) Standardized recipes (a set of written instructions used to consistently prepare a known quantity and quality of food), and (3) IDDSI Puree Level 4 food preparation. The DS will track and provide re-education to any dietary staff due to vacation or leave of absence to ensure 100 percent (%) education of all dietary staff. (continued on next page)

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	055287	A. Building B. Wing	01/22/2025

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	10. Beginning 1/22/2025, licensed nurses started conducting huddle rounds (a short, stand-up meeting for 10 minutes or less that is typically used once at the start of each shift), utilizing the huddle rounds form, with the certified nursing assistants (CNAs) and/or restorative nursing assistants (RNAs) every shift, daily, and as needed to observe and identify any potential concerns surrounding residents on an IDDSI Puree Level 4 diet during mealtimes and snacks for 30 days and then they (licensed nurses) will reevaluate. Any identified findings that need further investigation will be reported immediately to the RN Supervisor and/or designee for immediate follow up and to the resident's primary physician for possible speech therapy screen and/or evaluation as ordered. 11. Beginning 1/22/2025, during lunch mealtime, the licensed nurses started doing meal rounds where they review all meal trays prior to being served utilizing the Diet Roster report (includes the resident's diet order, diet consistency, and beverage consistency). The licensed nurses will review the residents' diet order, texture, and consistency to match with tray tickets (a menu that lists the food items a person will receive based on the resident's diet, allergies, likes/dislikes, and food preferences) and actual food served. A copy of the Diet Roster Report that was updated by the licensed nurse during the meal rounds will be given to the DON for further evaluation as necessary for 90 days. 12. Beginning on the week of 1/27/2025, the RD started conducting weekly visits and observation rounds in the Dietary Department for review and evaluation of practices, particularly food preparation of IDDSI Puree Level 4. The results of the RD's visit and observations will be given to the DS and the ADM for further follow-up as needed. 13. The DON and/or designee will report a summary-trend analysis (a process of examining and evaluating past data to identify patterns, recurrent trends and make informed decisions and changes in outcomes) of the huddle rounds conducted and the tray pass findings (a discovery of mistakes by not following recipes and diet consistencies) to the Quality Assurance (QA- a data driven proactive approach to improvement used to ensure services are meeting quality standards) meeting monthly for three months for review and evaluation of effectiveness or until the deficient practice is resolved. The initial presentation to the QA committee was on 1/28/2025 with benchmark (a standard or point of reference used to compare and measure the quality of performance and outcomes of healthcare services) of compliance of 100%. On 1/22/2025 at 8:24 p.m., while onsite and after verifying the facility's full implementation of the IJ Removal Plan, the SSA accepted the IJ Removal Plan and removed the IJ in the presence of the ADM, the DON, and the ADON. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated the facility originally admitted Resident 1 on 2/27/2023 and readmitted Resident 1 on 1/17/2025 with diagnoses including dysphagia oropharyngeal phase (swallowing problems occurring in the mouth and/or throat), gastro-esophageal reflux disease (GERD- a condition in which the stomach contents move up into the esophagus [muscular tube that connects the mouth to the stomach]), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar [glucose]), and sepsis (a serious condition in which the body responds improperly to an infection). (continued on next page)

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	01/22/2025

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 11/27/2024, the MDS indicated Resident 1 understood others and made self understood. The MDS indicated Resident 1 required supervision or touching assistance with eating (the ability to use suitable utensils to bring food/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident) and partial/moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with oral hygiene. The MDS indicated Resident 1 required a mechanically altered (food texture that is intended to be safe and easy to swallow) diet. During a review of Resident 1's General Acute Care Hospital 1 (GACH 1) Patient Discharge Instructions, dated 1/17/2025, the Patient Discharge Instructions indicated dietary recommendations for puree and no added salt (NAS- no salt packet on the meal tray) diet. During a review of Resident 1's History and Physical (H&P), dated 1/18/2025, the (H&P) indicated the resident (Resident 1) does not have the capacity to make decisions. During a review of Resident 1's Speech Therapy Treatment Encounter Note, dated 1/18/2025, the Speech Therapy Treatment Encounter Note indicated swallow treatment that included alteration of textures and temperatures to facilitate sensation and bolus (a ball-like mixture of food and saliva that forms in the mouth during the process of chewing) clearance. The Speech Therapy Treatment Encounter Note indicated Resident 1's current diet of puree consistencies and thin liquids. During a review of Resident 1's Speech Therapy: SLP Evaluation and Plan of Treatment, with start of care date of 1/19/2025, the SLP Evaluation and Plan of Treatment indicated recommendations for puree consistencies, thin liquids, close supervision. The SLP Evaluation and Plan of Treatment also indicated Resident 1's risk factors (variables or conditions that increase the likelihood of a specific adverse event or disease occurring) due to physical impairments and functional deficits, risk for aspiration, compromised general health, pneumonia (lung infection), and weight loss. During a review of Resident 1's Order Summary Report, dated 1/19/2025, the Order Summary Report indicated a physician's order for regular, NAS, puree texture, thin consistency (no restrictions). During a review of Resident 1's Baseline Care Plan, dated 1/17/2025, the Baseline Care Plan indicated Resident 1 needed set-up help with eating and was on mechanically altered diet and puree, no added salt diet. The Baseline Care Plan indicated the resident's dietary risks for weight loss as well as swallowing problems and chewing problems. During a review of the facility's menu spreadsheet (a sheet that contains each diet and what food and portions each diet would get) titled Therapeutic Spreadsheet Cycle 4 2024, dated 1/19/2025, the spreadsheet indicated residents on puree diet in accordance with IDDSI Level 4 would include the following in the meal tray: o Puree baked ham number eight (#8) scoop (1/2) cup (c., a household measurement) o Puree baked sweet potato #12 scoop (1/3 c) o Puree seasonal zucchini #10 scoop (3.25 ounces [oz, a unit of measurement]) (continued on next page)

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	01/22/2025

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o Puree bread one (1) piece (pc, a household measurement) o Margarine one (1) pc o Applesauce 1/2 c o Water eight (8) oz During food preparation observation on 1/19/2025 at 11:52 a.m., with [NAME] 1, in the kitchen, observed [NAME] 1 prepared puree bread and poured thickener (a substance used to increase the viscosity [the measure of a fluid's resistance to flow] of liquids to help support a safer swallow for residents) into the container without measuring the amount of the thickener. During a concurrent observation and interview on 1/19/2025 at 12:45 p.m., with Certified Nurse Assistant 5 (CNA 5), in Resident 1's room, observed at Resident 1's bedside (refers to the area at the side of a bed), Resident 1's lunch tray ticket indicated soup of the day six (6) oz, baked ham, baked sweet potato, seasonal zucchini, one bread, one margarine, applesauce, fruit cup, water eight (8) oz, Lactaid (a non-dairy milk substitute) eight (8) oz, and no gravy. Observed CNA 5 assisting Resident 1 with feeding puree bread. CNA 5 stated the puree bread was a little sticky. During an interview on 1/19/2025 at 1:02 p.m., with [NAME] 1, [NAME] 1 stated puree food should be smooth and must maintain its shape on the plate. [NAME] 1 stated she did not measure the puree bread and the thickener when making the puree bread. [NAME] 1 then stated she just used her eyes and gradually mixed the thickener when making the puree bread. [NAME] 1 stated she would then know that the puree food was on its proper texture and consistency based on how she feels and based on her past experiences. [NAME] 1 stated she was taught (unable to recall who) how to perform the spoon tilt test. [NAME] 1 also stated that puree diet is for residents who could not swallow, and if the food served was not in the right texture and consistency, residents could be placed at high risk for choking (when a person can't speak, cough, or breathe because something is blocking [obstructing] the airway). During a concurrent observation of the test tray (a process of tasting, temping [measuring the temperature of food to ensure it is safe to eat] and evaluating the quality of food) and interview on 1/19/2025 at 1:04 p.m., with the DS, the DS stated the puree bread did not pass the puree spoon tilt test when she (DS) performed it. The DS stated the puree bread was too sticky. The DS stated there were recipes available for the staff to follow for puree and there were also scoops and measuring cups for the kitchen staff to use to ensure accuracy of the puree consistency. The DS stated [NAME] 1 should not be eyeballing the ingredients or the thickener. The DS stated [NAME] 1 was not following the recipe. The DS stated the puree bread did not fall when she (DS) performed the spoon-tilt test as it was sticky and could potentially cause residents to have difficulty swallowing leading to choking. (continued on next page)

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	01/22/2025

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

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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 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/20/2025 at 10:04 a.m. with Speech Therapist 1 (ST 1), the ST 1 stated she recommends puree diet for residents who are weak, had impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses), and residents with dementia (a term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) for their safety. ST 1 stated puree diets are also recommended for residents who could not chew and had no teeth and those who had difficulty swallowing. ST 1 stated puree diet consisted of food that are smooth with no chunks or lumps and should not be watery. ST 1 stated the IDDSI standard used spoon tilt test and if the food did not fall off the spoon, it meant the food was too thick. ST 1 stated if food was too thick, there would be more bolus collection, and the food would be more difficult to swallow and harder for residents to get it down their throats. ST 1 stated Resident 1 and other residents with dysphagia diagnosis, on puree diet who received food not passing a puree texture could result to choking, aspiration, and weight loss as residents would not be able to eat as much food. During an interview on 1/20/2025 at 11:58 a.m. with the RD, the RD stated she (RD) talked to the kitchen staff regarding puree diet and the spoon tilt test. The RD stated if the food did not pass the spoon tilt test, it could be too thick as the slurry (a mixture of fluid/liquid and thickener) was not done correctly. The RD stated if the puree food was too thick, Resident 1 and other residents could experience swallowing difficulties and choking hazards. During an interview on 1/22/2025 at 6:32 a.m., with the DSD, the DSD stated CNAs should test the puree consistency for residents on puree diets. The DSD stated when the CNAs identify it is not the correct consistency, such as too thick, the CNAs should report to the charge nurse or can go to the dietary staff, cook, or to the DS, and request for food replacement as soon as possible. The DSD stated Resident 1 and other residents on puree diet who received thick puree consistency could have experienced choking and could have led to an emergency. During an interview on 1/22/2025 at 1:16 p.m., with the DON, the DON stated CNAs should check the consistency of food and that it should hold its shape and fork tender (refers to a food items, cooked to the point where it is soft enough to be easily pierced and shredded with a fork). The DON stated the puree food should be smooth, free of lumps, not watery, and holds it shape. The DON stated the puree food should pass the spoon-tilt test method. The DON stated if the puree food does not fall off the spoon, it did not pass the test. The DON stated if the puree food does not fall, and it is sticking on the spoon then it could be dry and could stick to the resident's throat. The DON stated Resident 1 could choke and could affect Resident 1's swallowing. During a review of the facility's policy and procedure (P&P) titled, Menus, dated 7/30/2024, the document indicated, Menus are developed and prepared to meet resident's choices including religious, cultural, and ethnic needs while following established national guidelines for nutritional adequacy. During a review of the facility's P&P titled Diet Manual, dated 7/30/2024, the P&P indicated, (4) The diet manual has been developed to provide explanation of the diets in the development of the menu program. The diets have been developed using current specific research, information from best practices, and recommendations from position papers of professional associations. (6) The diet manual is intended as a guide for the physician or other qualified healthcare professional to use in prescribing modified diets and for the health and care personnel in following diet order. (continued on next page)

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	01/22/2025

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of the facility's diet manual titled Dysphagia Diets Puree IDDSI Level 4, dated 7/30/2024, the diet manual indicated, A diet used in the dietary management of dysphagia with the food texture prepared lump-free, not firm, or sticky and holds its shape on a plate. The diet requires no biting and chewing. Any liquids must not separate from the food and the food fall off a spoon intact. The food is more easily swallowed and prevents aspiration. (3) Should not be sticky. The diet manual indicated that all prepared puree recipes should be tested prior to service to ensure the texture meets the IDDSI guidelines and should pass the Fork Drip test and Spoon Tilt Test. During a review of the facility's P&P titled Standardized Recipes, dated 7/30/2024, the P&P indicated standardized recipes shall be developed and used in the preparation of foods. The P&P indicated that only tested , standardized will be used to prepare foods and will be adjusted to the number of portions required for a meal. During a review of the recipe Bread Slice for Cycle 4 2024, the recipe indicated it is recommended to serve puree or gelled bread for dysphagia diets, but if the SLP of the facility signs and approves regular breads on an individual basis, chop regular portions. Make sure all particles are no more than 15 millimeters (mm, a unit of measurement) x 15 mm (1/2 inches [in, a unit of measurement]) in size. The recipe indicated to use puree bread mix.

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	055287	A. Building B. Wing	01/22/2025

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F 0808 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 38552 Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 32) received and consumed food as prescribed by the physician by failing to ensure Resident 32 consumed a mechanical soft finely chopped diet (a texture-modified diet that is prepared by finely chopping ingredients into small pieces, making it easier to chew and swallow for residents who have difficulty with regular food texture due to conditions like dysphagia [swallowing difficulties]) as ordered by the physician and did not consume a biscuit at dinner on 1/18/2025. This deficient practice had the potential to cause Resident 1 to not be able to eat the food, choke (when food gets stuck in your airway, blocking the flow of air to your lungs), and aspirate (when food or liquid enters your airway and lungs instead of your stomach) on the food. On 1/20/2025 at 9:39 p.m., while onsite at the facility, the State Survey Agency (SSA) called an Immediate Jeopardy (IJ- a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death to a resident) under 42 CFR S483.60 Food and Nutrition Services in the presence of the Administrator (ADM) and the Director of Nursing (DON) due to the facility's failure to ensure Resident 32 consumed a mechanical soft finely chopped diet as ordered by the physician and did not consume a biscuit at dinner on 1/18/2025. On 1/22/2025 at 12:48 p.m., the ADM provided an IJ Removal Plan (a plan that identifies all actions the facility will take to immediately address the noncompliance that has resulted in the IJ situation) which included the following summarized actions: 1. On 1/20/2025, Speech Therapist (known as speech language pathologist [SLP], who evaluates and treats communication disorders and swallowing issues) 1 (ST 1) completed an evaluation of Resident 32 and recommended to change the diet to puree texture (a texture modified diet that consists of smooth foods with pudding-like consistency that are easy to swallow), mildly thick liquid consistency (liquid that falls off a spoon, effort is required to drink through a standard straw) due to frequently coughing up food during swallow and wet or gurgly voice quality after swallowing liquids 2. On 1/21/2025, the Director of Nursing (DON) initiated a change of condition (a nursing assessment and evaluation when there is a sudden change in a resident's condition) for Resident 32 and notified the resident's physician and responsible party of the resident's risk for aspiration (when food, liquid, or other material enters the lungs that can occur when swallowing). Resident 32 was placed on a 72-hour monitoring and a care plan was developed. Resident 32's physician ordered to continue ST 1's recommendation placed on 1/20/2025. 3. On 1/21/2025, the Registered Dietitian (RD) provided an in-service (staff training) to the DON and the Director of Staff Development (DSD) regarding food texture consistencies and the International Dysphagia Diet Initiative (IDDSI - a framework for categorizing food textures and drink thickness) crosswalk reference guide (allows healthcare staff how another standard aligns with the facility's current standard used). (continued on next page)

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	055287	A. Building B. Wing	01/22/2025

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F 0808 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. On 1/22/2025, the RD presented the IDDSI crosswalk reference guide to be used as a reference for licensed nurses when transcribing (writing) a hospital diet order to facility diet order which utilizes the IDDSI framework. 5. On 1/21/2025, the DON and the DSD initiated in-service trainings to the licensed nurses, certified nursing assistants (CNAs), and restorative nursing assistants (RNAs) on duty regarding transcription of diet orders upon admission and utilization of crosswalk reference guide for the IDDSI equivalent, aspiration precautions (safety measures taken to prevent food or liquid from accidentally entering the airway while eating or drinking), signs and symptoms of aspiration, diet communication, diet transcription and verification, meal cart check process, and meal observation. The validation of competency (able to perform tasks successfully) was done through question and answer (Q&A). The DON and the DSD deemed the in-serviced staff were competent. 6. On 1/21/2025, the DON reviewed the current residents' diet orders. No other residents on mechanical soft diet (a type of texture-modified diet for residents who have difficulty chewing and swallowing) were affected by the deficient practice. 7. Beginning 1/21/2025, newly admitted and readmitted residents were reviewed by the Assistant Director of Nursing (ADON), Registered Nurse (RN) Supervisor and/or designee prior to their first meal being served daily, including weekends and holidays, for appropriateness of diet order utilizing the IDDSI crosswalk reference guide and utilizing the clinical meeting tool (a communication tool that reviews the effectiveness of clinical systems and to review individual residents as appropriate) for 90 days or until 100 percent (%) compliance is reached. 8. Beginning 1/21/2025, ST 1 conducted screening and/or evaluation of newly admitted or readmitted residents with a mechanically altered (food texture that is intended to be safe and easy to swallow) diet within 72 hours of admission and any recommendations will be reported to the physician and the licensed nurse. 9. Beginning 1/21/2025, the DON and the DSD started providing in-services to the nursing staff (licensed nurses and CNAs) regarding transcription of diet orders upon admission, IDDSI crosswalk reference guide, aspiration precautions, signs and symptoms of aspiration, diet communication, diet transcription and verification, meal cart check process, and meal observation. The DSD will be responsible to track compliance and any nursing staff that were not re-educated due to vacation and or leave of absence will be provided re-education prior to the start of their next shift. Validation of compliance will be through a post-test (a test given to training participants after the instruction is presented or completed). 10. Beginning 1/21/2025, the DON and/or designee started providing in-services to the licensed nurses (RN and Licensed Vocational Nurse [LVN]) regarding verification of diet orders from written hospital orders, IDDSI crosswalk reference guide, and verifying diet orders with the primary physician. Validation of compliance will be through a post-test. (continued on next page)

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	055287	A. Building B. Wing	01/22/2025

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F 0808 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	11. The DON and/or designee will present a summary trend analysis (a method of evaluating and comparing data and patterns over time, particularly before and after systematic changes) of the Clinical Meeting reviews particularly with diet orders of newly admitted and/or readmitted residents and licensed nurses' meal rounds report (a copy of the Diet Roster report [includes the residents' diet order, diet consistency, and beverage consistency] that was updated by the licensed nurses during the meal rounds [where licensed nurses review all meal trays before being served against the Diet Roster report]) monthly for three (3) months to the Quality Assurance (QA- a data driven proactive approach to improvement used to ensure services are meeting quality standards) committee for further evaluations and recommendations. Monitoring systems are to remain in place for three (3) months to be evaluated for future systems monitoring as needed by the QA Committee. The initial presentation on the QA committee was on 1/28/2025 with benchmark (a standard or point of reference used to compare and measure the quality of performance and outcomes of healthcare services) of compliance of 100%. On 1/22/2025 at 8:24 p.m., while onsite and after verifying the facility's full implementation of the IJ Removal Plan, the SSA accepted the IJ Removal Plan and removed the IJ in the presence of the ADM, the DON, and the ADON. Findings: During a review of Resident 32's Admission Record, the Admission Record indicated the facility originally admitted Resident 32 on 7/30/2019 and readmitted Resident 32 on 4/18/2024 with diagnoses including chronic obstructive pulmonary disease (COPD- a lung disease causing restricted airflow and breathing problems) with acute (sudden) exacerbation (worsening), dysphagia oropharyngeal phase (swallowing problems occurring in the mouth and/or throat), and dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). During a review of Resident 32's History and Physical (H&P), dated 4/20/2024, the H&P indicated Resident 32 has the capacity to understand and make decisions. During a review of Resident 32's Minimum Data Set (MDS-a resident assessment tool), dated 11/20/2024, the MDS indicated Resident 32 made self understood and had the ability to understand others. The MDS indicated Resident 32 required supervision or touching assistance with eating (the ability to use suitable utensils to bring food/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident). The MDS indicated the resident required partial/moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with oral hygiene, upper body dressing, and personal hygiene. During a review of Resident 32's Physician Orders, dated 4/22/2024, the Physician Orders indicated regular, large portions diet (adding a portion of food to the meal tray), Puree texture Level Four (refers to puree foods and extremely thick drinks in accordance with IDDSI framework Level 4 Standards), nectar mildly thick consistency (consistency of liquid slightly thicker than water and can flow through a standard straw) for teaspoon sips of nectar thick liquids only. The Physician's Order was discontinued on 1/16/2025. During a review of Resident 32's General Acute Care Hospital 1 (GACH 1) Ambulatory Assessment Inquiry (data collection method), dated 1/14/2025, the Ambulatory Assessment Inquiry indicated the speech therapy swallow evaluation specified mechanical soft finely chopped diet consistency. (continued on next page)

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	055287	A. Building B. Wing	01/22/2025

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F 0808 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 32's GACH 1's Patient Discharge Instructions, dated 1/17/2025, the Patient Discharge Instructions indicated a dietary restriction (a limitation on what food or ingredient a person eats) of mechanical soft finely chopped. During a review of Resident 32's Physician Orders, the Physician Orders indicated: - Reduced concentrated sweets diet (RCS diet - no sweet foods and sugar in the diet), mechanical soft chopped meat texture, thin consistency, dated 1/18/2025. The physician's order was discontinued on 1/20/2025. - RCS diet, puree texture, mildly thick consistency, dated 1/20/2025. During a review of Resident 32's care plan with focus on Potential for decline in ability to safely self-feed, with a revised date of 11/28/2024, the care plan indicated interventions including puree texture diet and no thin liquids including water, ice chips, thin soups, and Jell-O (brand name for a soft, sweet, usually brightly colored food made from sugar, gelatine, and fruit flavors, that shakes slightly when it is moved). During a review of Resident 32's care plan with focus on the resident has a swallowing problem related to a nectar thickened liquid, with a revised date of 11/28/2024, the care plan indicated interventions including: - Diet to be followed as prescribed. Regular, large portions diet, puree texture level four, nectar mildly thick consistency. - Monitor for shortness of breath, choking (happens when an object or food lodges in the throat blocking the flow of air), labored respirations (difficulty breathing), lung congestion (a condition where the lungs fill with fluid or blood). - Monitor/document/report to nurse/dietitian and physician as needed for difficulty swallowing, prolonged swallowing time, throat clearing, and coughing. During a review of Resident 32's ST Discharge Summary, dated 5/16/2024, the ST Discharge Summary indicated discharge recommendations of puree diet consistency and nectar liquid. During a review of the facility's menu spreadsheet (a sheet that contains each diet and what food and portions each diet would get) titled Therapeutic Spreadsheet Cycle 4 2024, dated 1/18/2025, the spreadsheet indicated residents on mechanical soft diet would include the following foods on the dinner tray: o Ground roast turkey two (2) ounces (oz, a unit of measurement) o Dressing o Finely chopped seasonal brussels sprouts o Biscuit one (1) each (continued on next page)

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	055287	A. Building B. Wing	01/22/2025

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F 0808 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o Chopped banana strawberry 1/2 cup (c, a household measurement) o Water eight (8) oz o Nutritional shake one (1) each o Coffee eight (8) oz o Milk whole eight (8) oz During a concurrent observation and interview on 1/18/2025 at 5:53 p.m., with Certified Nurse Assistant 2 (CNA 2), in Resident 32's room, observed CNA 2 assisting Resident 32 with his dinner meal tray. Resident 32's meal tray ticket (a menu that lists the food items a resident will receive based on the resident's diet, allergies, likes/dislikes, and food preferences) indicated RCS diet, mechanical soft, chopped meat with thin liquid consistency. CNA 2 stated Resident 32's meal plate contained a biscuit, vegetable, and meat. Observed CNA 2 break the biscuit into small pieces using a spoon. CNA 2 stated that she (CNA 2) has to break the biscuit into small pieces to be consumed by Resident 32. Resident 32 was observed making gurgling sounds, his (Resident 32) face appeared flushed, and was rocking forward while eating. When CNA 2 was asked what sound Resident 32 was making, CNA 2 stated Resident 32 was making sounds as if he was tasting his food. CNA 2 continued to feed Resident 32 with biscuits from a spoon and stated that Resident 32 was fine. During a continued concurrent observation and interview on 1/18/2025 at 6:13 p.m., with CNA 2, at Resident 32's bedside (refers to the area at the side of a bed), observed CNA 2 serving Resident 32 with the chopped biscuits to eat using a spoon. Observed Resident 32 made gurgling sounds, Resident 32's face appeared flushed and made rocking forward motion while eating on bed. CNA 2 then asked Resident 32 if he was okay. Resident 32 did not answer yes or no and answered to give him more food. Observed CNA 2 offered juice and milk to Resident 32 and Resident 32 drank the juice. When CNA 2 was asked what sound Resident 32 was making, CNA 2 stated Resident 32 was making tasting sounds, and that the resident was fine. Observed CNA 2 continued to serve Resident 32 with biscuits to eat using a spoon. During a concurrent interview and record review on 1/18/2025 at 6:15 p.m., with Registered Nurse 1 (RN 1), Resident 32's Physician's Order dated 1/18/2025 was reviewed. The Physician's Order indicated RCS diet, mechanical soft, chopped meat texture, thin consistency. RN 1 stated she (RN 1) received Resident 32's diet order and report from GACH 1. RN 1 stated she (RN 1) based Resident 32's diet order on GACH 1's Resident/Patient Transfer Form, dated 1/17/2025, which indicated mechanical soft diet, and that the ADON assisted in inputting Resident 32's diet order in their facility's electronic health record (EHR- an electronic version of a resident's medical history). During a concurrent interview and record review on 1/18/2025 at 6:17 p.m., with RN 1, Resident 32's GACH 1 Patient's Discharge Instructions dated 1/17/2025 was reviewed. RN 1 stated she (RN 1) does not review the Patient's Discharge Instructions and only reviews the GACH's Resident Patient Transfer Form with the verbal report from the hospital discharging nurse. RN 1 stated she then relays that information to the resident's physician. RN 1 stated GACH 1's Resident Patient Transfer Form dated 1/17/2025 indicated mechanical soft only while GACH 1's Patient Discharge Instructions dated 1/17/2025 indicated mechanical soft finely chopped diet. (continued on next page)

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	055287	A. Building B. Wing	01/22/2025

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F 0808 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/19/2025 at 4:02 p.m., RN 1 stated she (RN 1) assumed that the mechanical soft diet order was mechanical soft, chopped meat diet order on their electronic health record. RN 1 stated she has not received any training about the IDDSI. During an interview on 1/19/2025 at 5:57 p.m. with the DS, the DS stated the facility started implementing the IDDSI diet on 1/1/2025 but does not have residents on soft and bite sized diet Level 6 (foods that are soft, tender, and moist with no separate thin liquid). The DS stated the facility did not have finely chopped food in their diet manual. The DS stated nurses have not been trained regarding IDDSI. During an interview on 1/20/2025 at 8:43 a.m. with the DS, the DS stated the finely chopped diet are foods consisted of food chopped to 1/8 to 1/2 inch (in - unit of measure) in size. The DS stated all the levels for IDDSI are not fully implemented yet as it would take time for the ST to implement. The DS stated finely chopped diet was equivalent to minced (cut up or ground into very small pieces) and moist, Level 5 (modified food textures to enhance chewing and swallowing abilities such as pre-gelled soaked breads, minced or mashed vegetables, finely minced meats 4 millimeters [mm, a unit of measurement] x 15 mm]) food. During an interview on 1/20/2025 at 10:04 a.m., with ST 1, ST 1 stated Resident 32 and other residents on soft mechanical diet should not be getting biscuits, as they were very dry and hard to chew. ST 1 stated Resident 32 and other residents could be fatigued when eating biscuits and may lead to choking and aspiration. During an interview on 1/20/2025 at 11:43 a.m. with the RD, the RD stated they have implemented IDDSI standards for residents with dysphagia. The RD stated Puree diet is IDDSI Level 4, minced and moist is IDDSI Level 5, soft bite-sized is IDDSI Level 6, and mechanical soft ground has no level because this diet was for residents with missing tooth issues and not for residents with dysphagia. The RD stated Resident 32 and other residents with dysphagia diagnosis could have choking episodes if given biscuits. The RD stated Resident 32, who was prescribed with soft mechanical chopped diet should be given minced and moist IDDSI Level 5 as it was the safest compared to soft mechanical ground with no levels. During an interview on 1/22/2025 at 6:32 a.m., with the DSD, the DSD stated Resident 32 required assistance and cueing when eating because he (Resident 32) tends to eat fast. The DSD stated when a CNA observed signs and symptoms of aspiration such as coughing, shortness of breath, chest pain, or change in color, the CNA should stop assisting the resident with feeding. The DSD stated the CNA should call the charge nurse or any licensed nurse before proceeding to assist the resident with feeding. The DSD stated the resident could have aspirated and the resident could have experienced respiratory distress (breathing difficulties). The DSD stated nursing staff have not been in-serviced regarding IDDSI. The DSD stated when employees are not trained well, they could jeopardize the safety of the residents. The DSD stated for example when spoon tilt test (a method used to determine the stickiness of food and ability of the food to hold together) is not done then the food can be too thick, and residents are prone to choking. (continued on next page)

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	055287	A. Building B. Wing	01/22/2025

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Valley Palms Care Center	13400 Sherman Way N Hollywood, CA 91605

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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 0808 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/22/2025 at 11:59 a.m., with ST 1, ST 1 stated Resident 32 was placed back to puree diet and mildly thick liquid. ST 1 stated this was because of the resident's poor cognition (the mental action or process of acquiring knowledge and understanding through thought, experience and the senses), impulsiveness (tendency to act without thinking), and agitation (unable to relax and be still). ST 1 stated Resident 32 eats at a very fast pace which makes it dangerous. During an interview on 1/22/2025 at 1:11 p.m., with the DON, the DON stated the expectation for the CNA is to know what signs of aspiration are and what to look for including coughing, shortness of breath, difficulty swallowing, and holding on to their throat. The DON also stated when signs of aspiration are observed, the CNA should notify the licensed nurse right away for the resident to be assessed immediately. The DON stated the CNA should hold (stop) assisting the resident with feeding, and if needed call the emergency code so more nurses can assist. The DON stated they are trying to avoid a more aggravating condition and prevent the resident from choking or aspirating. During an interview on 1/22/2025 at 1:41 p.m., with the DON, the DON stated RN 1 should have reviewed GACH 1's Patient Discharge Instructions where the diet order was indicated. The DON stated the GACH Resident Patient Transfer Form is just a tool that the discharge nurse from the hospital fills out. The DON stated RN 1 should have based the physician diet orders from the hospital's Patient Discharge Instructions and physician order when the primary physician was notified. The DON stated the RN verifying the diet order should ensure that it was the appropriate diet and should indicate the reason for the specific diet. The DON stated when the RN do not verify the GACH discharge diet orders, the resident could potentially be given the wrong diet and could potentially aspirate. During a review of the facility's policies and procedures (P&P) titled Menus, dated 7/30/2024, the P&P indicated, Menus are developed and prepared to meet resident choices including religious, cultural, and ethnical need while following established national guidelines for nutritional adequacy. During a review of the facility's P&P titled Diet Manual, dated 7/30/2024, the P&P indicated, (4) The diet manual has been developed to provide explanation of the diets in the development of the menu program. The diets have been developed using current specific research, information from best practices, and recommendations from position papers of professional associations. (6) The diet manual is intended as a guide for the physician or other qualified healthcare professional to use in prescribing modified diets and for the health and care personnel in following diet order. During a review of the facility's diet manual titled Minced and Moist Diet, IDDSI Level 5-MM5*, dated 7/30/2024, the diet manual indicated A diet used in the management of dysphagia with the food texture prepared as minced and moist. Can be used if you are not able to bite off foods safely but have some basic chewing ability. Some people on this diet may be able to bite off a large piece of food but they are unable to chew it into small enough pieces that are safe to swallow. Approximate size: 4 mm (1/8 inches) lumps. All recipes should be tested prior to service to ensure the texture and pieces size meet the IDDSI guidelines. Bread: Menu utilizes puree bread mix for this level. Pre-gelled soaked breads that are very moist and gelled through the entire thickness and no regular, dry bread. During a review of the facility's P&P titled Standardized Recipes, dated 7/30/2024, the P&P indicated standardized recipes shall be developed and used in the preparation of foods. The P&P indicated that only tested , standardized will be used to prepare foods and will be adjusted to the number of portions required for a meal. (continued on next page)

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F 0808 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of the facility's recipe titled Biscuit (Mix), dated 7/30/2024, the recipe indicated, it is recommended to serve pureed bread/biscuit for dysphagia diet unless the SLP at your facility signs and approves regular bread on individual basis, serve regular unmodified portion. During a review of the facility's P&P titled Therapeutic Diets, dated 7/30/2024, the P&P indicated Therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his or goals and preferences. Policy Interpretation and Implementation: 1. Diet will be determined in accordance with the resident's informed choices, preferences, treatment goals and wishes. Diagnosis alone will not determine whether the resident is prescribed a therapeutic diet. 2. A therapeutic diet must be prescribed by the resident's attending physician (or non-physician provider). The attending physician may delegate this task to a registered or licensed dietitian as permitted by state law. 3. Diet order should match the terminology used by the food and nutrition services department. 4. A therapeutic diet is considered a diet ordered by a physician, practitioner, or dietitian as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet, or to alter the texture of a diet, for example: altered consistency diet. 5. If a mechanically altered diet is ordered, the provider will specify the texture modification.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43878 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: 1. Resident foods were not labeled and dated. 2. Staff foods were stored in the kitchen refrigerator. These deficient practices had the potential to result in harmful bacterial growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 88 of 92 medically compromised residents who received food. Findings: During an initial tour of the kitchen on 1/18/2025 at 7:14 a.m. observed: - a container half empty humus, no dates noted. - a container with a prepared mashed up food item covered, no dates noted. - Three (3) bowls with cut oranges no dates noted. During a concurrent observation and interview on 1/18/2025 at 7:34 a.m. with Dietary Aide 3 (DA 3), DA 3 stated the mashed up food item was mashed potatoes. DA 3 stated both the humus and the mashed potatoes do not belong to residents but to staff. DA 3 stated staff food should not be kept in the resident's refrigerator. DA 3 stated the oranges do not have a date when they were cut and they cannot verify when the oranges were cut. DA 3 stated the oranges were already hard and will discard them. During an interview on 1/20/2025 at 4:39 p.m. with the Dietary Supervisor (DS), the DS stated they were aware that staff food was in the kitchen refrigerator. The DS stated in previous facility she worked, staff were not able to put their food in the resident refrigerator but in the current facility, their policy does not specify. The DS stated the hummus was store-bought while the mashed potatoes were homemade. During an interview on 1/20/2025 at 5:06 p.m. with the DS, the DS stated the staff food in the resident refrigerator did not have name, opened date, and/or use by date. The DS stated for the three (3) bowls of oranges, there was no date when it was made and no use by date. The DS stated the food items should have been labeled with both use by date and made by date. During an interview on 1/22/2025 at 12:41 p.m. with the Director of Nursing (DON), the DON stated staff should not be placing their food items in the resident refrigerator as it was an infection control issue. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedures (P&P) titled, Food Receiving and Storage, last reviewed on 7/30/2024, the P&P indicated food shall be received and stored in a manner that complies with safe food and handling practices. 3. Foods that are prepared off site will only be accepted from institutions that are subject to federal, state, or local inspection. 8. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date). f. Partially eaten food may not be kept in the refrigerator. During a review of the facility's P&P titled, Policies and Practices Infection Control, last reviewed on 7/30/2024, the P&P indicated policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of disease and infections.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44244 Based on observation, interview, and record review, the facility failed to implement and maintain an infection control program by failing to: 1. Ensure Licensed Vocational Nurse 1 (LVN 1) implemented Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO, microorganisms, mainly bacteria, that are resistant to one or more classes of antibiotics] that uses targeted gown and glove use during high contact resident care activities) while administering medications to a resident with a gastrostomy tube (G-tube/GT - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) for one of seven sampled residents (Resident 73) reviewed under the Medication Administration task area. 2. Ensure a personal blanket was not stored on top of the discontinued medication bin in the Station A Medication Storage Room. 3. Ensuring personal belonging were not kept in one of two medication carts (Medication Cart 2 [MC 2]) reviewed under Medication Storage. 4. Ensure Resident 246's nasal cannula (a small plastic tube, which fits into a patient's nostrils for providing supplemental oxygen) tubing was labeled with the date it was last changed. 5. Failing to ensure Resident 84's nasal cannula tubing and hand-held nebulizer (a small machine that turns liquid medicine into a mist that can be easily inhaled) tubing were not touching the floor. 6. Failing to ensure Resident 3's nasal cannula tubing was not touching the floor. These deficient practices had the potential for the spread of infections. Findings: a. During a review of Resident 73's Admission Record, the Admission Record indicated the facility admitted the resident on 8/12/2024 with diagnoses that included metabolic encephalopathy (an alteration in consciousness due to brain dysfunction), gastrostomy, sepsis (a life-threatening blood infection), and dysphagia (difficulty swallowing). During a review of Resident 73's History and Physical dated 8/15/2024, the History and Physical indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 73's Minimum Data Set (MDS - resident assessment tool), dated 11/15/2024, the MDS indicated the resident sometimes was able to understand others and sometimes was able to make himself understood. The MDS further indicated the resident was dependent on staff for toileting and bathing and required partial/substantial staff assistance for dressing and mobility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 73's Care Plan (CP) regarding EBP related to GT and unhealed pressure injury wounds (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) stage 3 (Full-thickness loss of skin. Dead and black tissue may be visible), initiated 8/13/2024, the CP indicated place the EBP sign at the door and use a gown and gloves during high contact resident care activities. During a medication administration observation for Resident 73 on 1/19/2025 at 9:21 a.m., observed an EBP sign posted at the entry to Resident 73's room. Observed LVN 1 enter Resident 73's room, sanitize her hands, donned (put on) a pair gloves, pulled back Resident 73's blanket and accessed the G-tube for placement. After discarding the gloves and sanitizing her hands, LVN 1 prepared Resident 73's medication, re-entered the room, donned a pair of gloves, accessed the G-tube, and administered the resident's medications via G-tube administration. LVN 1 then exited the room. Observed LVN did not wear a gown while accessing the G-tube or administering Resident 73's medications. During a concurrent interview and record review on 1/19/2025 at 9:44 a.m., with LVN 1 upon exiting Resident 73's room, LVN 1 stated Resident 73 had an EBP sign at the entry to his room because the resident has a G-tube. LVN 1 stated gloves and a gown should be worn when changing the resident. LVN 1 reviewed the EBP sign and noted gloves and gown should be worn during high contact activities like providing device care or use. LVN 1 stated she didn't usually wear a gown while administering medications via a G-tube. LVN 1 stated she was not sure if she should don a gown for EBP while administering medications to Resident 73, but she would follow up. During a follow up interview on 1/19/2025 at 9:50 a.m., with LVN 1, LVN 1 stated she spoke with the facility Infection Preventionist (IP) and the IP told her she must wear a gown for EBP during a G-tube medication administration to reduce the transmission of organisms to the resident. During a concurrent interview and record review on 1/20/2025 with the Director of Nursing (DON), the DON reviewed the facility policy and procedures regarding EBP and infection control. The DON stated residents with G-tubes are at increased risk of infection because they have an opening leading to the inside of their body that could be a portal of entry for infections. The DON stated wearing a gown during G-tube medication administration helps prevent the transfer of microbes from staff clothing to the resident. The DON stated when LVN 1 did not don a gown while administering medications to Resident 73, the facility policy and procedures for EBP and infection control were not followed. During a review of the facility Policy and Procedure (P&P) titled, Enhanced Barrier Precautions, last reviewed 7/30/2024, the P&P indicated EBP are utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents. EBP are used as an infection prevention and control intervention that employs targeted gown and glove use during high contact resident care activities. Gloves and gown are applied prior to performing the high contact resident care activity. Examples of high contact resident care activities requiring the use of gown and gloves for EBPs include device use (feeding tube). EBPs are indicated for residents with indwelling medical devices regardless of MDRO colonization. EBPs remain in place for the duration of the resident's stay or until discontinuation of the indwelling medical device that places them at increased risk. Staff are trained prior to caring for residents on EBPs. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility P&P titled, Policies and Practices - Infection Control, last reviewed 7/30/2025, the P&P indicated the facilities infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. All personnel will be trained on the infection control policies and practices upon hire and periodically thereafter. b. During a medication storage observation on 1/19/2024 at 10:32 a.m. of the Station A Medication Storage Room, with Licensed Vocational Nurse 9 (LVN 9), observed a folded, white blanket with multicolored trees placed on top of a bin labeled discontinued medication. LVN 9 stated he did not know why the blanket was in the medication room, but it should not be there. LVN 9 stated he did not know if the blanket belonged to a resident or a staff member or if it was clean or dirty. LVN 9 stated blankets should not be in the medication room for infection control. Observed LVN 9 did not remove the blanket from the medication room. During an interview on 1/19/2025 at 10:51 a.m. with Registered Nurse 1 (RN 1), RN 1 entered the Station A Medication Room and stated the blanket was still in the room. RN 1 stated she was not sure if the blanket was used, but blankets should not be left in the medication room for infection control and sanitary reasons. RN 1 stated when a blanket is left in the medication room it can lead to cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect) of bacteria to the resident medications and cause illness of residents. During a concurrent interview and record review on 1/20/2025 at 9:07 a.m., with the Director of Nursing (DON), the DON reviewed the facility policy and procedures regarding infection control and medication storage. The DON stated resident, or staff personal belongings should not be in the medication rooms for infection control reasons. The DON stated any staff member that entered into the medication storage room and saw the blanket should have removed the blanket, but they did not. The DON stated she has spoken with staff, and nobody wants to own up to who the blanket belonged to. The DON stated the medication rooms stores medications that are administered to residents and any contamination from the blanket could transfer to the residents and medication carts causing illness. The DON stated the facility policies were not followed. During a review of the facility P&P titled, Storage of Medications, last reviewed 7/30/2025, the P&P indicated medications and biologicals are stored safely, securely, and properly. Medication storage areas are kept clean, and conditions are monitored on a routine basis and corrective action taken if problems are identified. During a review of the facility P&P titled, Policies and Practices - Infection Control, last reviewed 7/30/2025, the P&P indicated the facilities infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. All personnel will be trained on the infection control policies and practices upon hire and periodically thereafter. 43878 c. During a concurrent medication storage observation of MC 2 and interview with Licensed Nurse 7 (LVN 7) on 1/20/2025 at 10:18 a.m., observed the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Electric razor with no name. - Watch with no name. - Folding fan with no name - Car keys - Keys - Two (2) cellular phones - Charge for phone - Tagrisso (presription medication) 80 milligrams (mg, unit of measure) - 20 imaging compact discs (CDs) LVN 7 stated the electric razor, watch, folding fan, cell phones and charger had no names on who they belong to and those should not be in the medication cart. LVN 7 stated the car keys belonged to a resident that was discharged on [DATE], the keys belonged to a resident that was discharged on [DATE], the tagrisso belonged to a resident who was discharged on [DATE], and the CDs belonged to residents who may no longer be in the facility. LVN 7 stated only medications should be kept in the medication cart while residents' belongings should go with Social Services. During an interview on 1/22/2025 at 12:52 p.m. with the Director of Nursing (DON), the DON stated residents' belongings should not be stored in the medication cart. The DON stated storing residents' belonging can be a risk for infection. During a review of the facility's policy and procedures (P&P) titled, Policies and Practices Infection Control, last reviewed on 7/30/2024, the P&P indicated policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of disease and infections. All personnel will be trained on the infection control policies and practices upon hire and periodically thereafter. 43988 d. During a review of Resident 246's Admission Record, the Admission Record indicated the facility originally admitted the resident on 12/5/2024 and readmitted in the facility on 1/17/2025, with diagnoses including heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), lack of coordination, and generalized weakness. During a review of Resident 246's History and Physical (H&P) dated 1/18/2025, the H&P indicated Resident 246 had the capacity to understand and make decisions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 246's Minimum Data Set (MDS, a resident assessment tool), dated 12/10/2024, the MDS indicated the resident had an intact cognition (having the ability to think, learn, and remember clearly). The MDS indicated Resident 246 required supervision or touching assistance with eating; partial/moderate assistance with oral hygiene and personal hygiene; total assistance shower transfers, sit to lying and lying to sitting; substantial/maximal assistance with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 246 was on oxygen therapy on admission and while a resident in the facility. During a review of Resident 246's care plan on respiratory distress initiated on 12/12/2024, last revised on 12/19/2024, the care plan indicated to monitor respiratory status and administer oxygen therapy as prescribed. During an observation 1/18/2025 at 9:12 a.m., inside Resident 246's room with Certified Nursing Assistant 11 (CNA 11), CNA 11 verified Resident 246's nasal cannula tubing did not indicate the date of when it was last changed. CNA 11 stated the nasal cannula tubing are changed every week and should be labeled with the date but not sure of what days as they are changed by night shift staff. CNA 11 stated Resident 242's tubing should have been labeled it was last changed to ensure the tubing is not old which may lead to Resident 242 getting infection if the tubing was old and contaminated. During a concurrent observation and interview on 1/18/2025 at 9:20 a.m. inside Resident 246's room with the Infection Preventionist (IP), the IP verified Resident 242's nasal cannula tubing did not indicate the date it was last changed. The IP stated nasal cannula tubing on all residents are changed every week and the staff should indicate the date it was last changed. The IP stated Resident 242's nasal cannula tubing should have been labeled with the date it was last changed so the staff would be aware and to ensure the tubing was not contaminated due to not being changed on time which may lead to resident acquiring infection. During a review of the facility's policy and procedure (P&P) titled, Departmental (Respiratory Therapy) - Prevention of Infection, last reviewed on 7/30/2024, the P&P indicated to change the oxygen cannula and tubing every seven (7) days or as needed to prevent infection associated with respiratory therapy task and equipment among residents and staff. During a review of the facility P&P titled, Policies and Practices - Infection Control, last reviewed 7/30/2024, the P&P indicated the facilities infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. All personnel will be trained on the infection control policies and practices upon hire and periodically thereafter. e. During a review of Resident 84's Admission Record, the Admission Record indicated the facility admitted the resident on 12/25/2024, with diagnoses including acute respiratory failure with hypoxia (a serious condition that happens when the lungs cannot get enough oxygen into the blood causing a dangerously low level of oxygen in the body), a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), difficulty in walking, and generalized weakness. During a review of Resident 3's History and Physical (H&P) dated 12/26/2024, the H&P indicated Resident 84 had the capacity to understand and make decisions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 84's Minimum Data Set (MDS, a resident assessment tool), dated 12/30/2024, the MDS indicated the resident had an intact cognition (having the ability to think, learn, and remember clearly). The MDS indicated Resident 84 was independent with eating; partial/moderate assistance with oral hygiene, upper body dressing, personal hygiene, and rolling left to right; total assistance with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 84 was on oxygen therapy on admission and while a resident in the facility. During a review of Resident 84's Order Summary Report, the Order Summary Report indicated the following physician's orders dated 12/31/2024: - Oxygen at 3 liters per minute (liters/min - a unit of measurement) and may titrate to 4 liters/min via nasal cannula continuously to keep oxygen saturation (O2 sat - a measurement of how much oxygen the blood is carrying as a percentage) above 92 percent (% - a unit of measurement). - 12/31/2024 revised on 1/19/2025: ipratropium-albuterol inhalation solution (a combination medication used to treat breathing problems by relaxing the muscles in the airways, opening up the lungs to make it easier to breathe) 0.5-2.5 (3) milligram (mg - a unit of measurement) per 3 milliliters (ml - a unit of measurement) inhale orally via nebulizer every six (6) hours as needed for shortness of breath. - 12/31/2024 revised on 1/19/2025: levalbuterol hydrochloride (a medication used to treat wheezing [a high-pitched whistling sound a person makes when breathing when the airway is partially blocked] and shortness of breath that commonly occur with lung problems) inhalation nebulization solution 0.63 mg/3 ml 0. 63 mg inhale orally via nebulizer every 6 hours as needed for bronchospasm (it happens when the muscles around the airways in the lungs suddenly tighten up, making it hard to breathe) or wheezing. During a concurrent observation and interview on 1/18/2025 at 9:41 a.m., inside Resident 84's room with Certified Nursing Assistant 11 (CNA 11), CNA 11 verified Resident 84's nasal cannula tubing and nebulizer tubing did not indicate the date they were last changed and were touching the floor. CNA 11 stated all residents' nasal cannula and nebulizer tubing should not be touching the floor and should be labeled with the date they were last changed. CNA 11 stated any extra tubing that that had the potential to touch the floor should be placed inside the plastic storage bag to prevent from being contaminated floor. CNA 11 stated the nebulizer tubing should be placed inside the plastic storage bag after use. CNA 11 stated Resident 84's nasal cannula tubing and nebulizer tubing should not be touching the floor as it the floor was dirty and already contaminated the tubing. CNA 11 stated Resident 84's tubing should have been labeled with the date they were last changed as the resident can get infection from an old and contaminated tubing. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 1/18/2025 at 9:45 a.m. inside Resident 84's room with Registered Nurse 3 (RN 3), RN 3 verified Resident 84's nasal cannula tubing and nebulizer tubing did not indicate the date of when they were last changed and were touching the floor. RN 3 stated nasal cannula tubing and nebulizer tubing are changed every week by the night shift staff and should indicate the date the tubing were changed and staff should ensure all residents tubing were kept off floor or placed inside the plastic storage bag when not in use. RN 3 stated Resident 84' s nasal cannula and nebulizer tubing should have been labeled with the date it was last changed for staff to know that the tubing were not old and should have been kept off the floor as it placed the resident at risk for acquiring infection from an old and contaminated tubing. During an interview on 1/19/2025 at 9:20 a.m. with the Infection Preventionist (IP), the IP stated nasal cannula tubing and nebulizer stated nasal cannula tubing and nebulizer tubing are changed every week on Sundays by the night shift staff and should indicate the date the tubing were changed, and staff should ensure all residents tubing were kept off floor or placed inside the plastic storage bag when not in use. The IP stated Resident 84' s nasal cannula and nebulizer tubing should have been labeled with the date it was last changed for staff to know that the tubing were not old and should have been kept off the floor as it placed the resident at risk for acquiring infection if the tubing were old and contaminated. During a review of the facility's policy and procedure (P&P) titled, Departmental (Respiratory Therapy) - Prevention of Infection, last reviewed on 7/30/2024, the P&P indicated to change the oxygen cannula and tubing every seven (7) days or as needed and keep in a plastic bag when not in use to prevent infection associated with respiratory therapy task and equipment among residents and staff. During a review of the facility P&P titled, Policies and Practices - Infection Control, last reviewed 7/30/2024, the P&P indicated the facilities infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. All personnel will be trained on the infection control policies and practices upon hire and periodically thereafter. f. During a review of Resident 3's Admission Record, the Admission Record indicated the facility originally admitted the resident on 6/2/2024 and readmitted in the facility on 12/9/2024, with diagnoses including chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), heart failure (, and generalized weakness. During a review of Resident 3's History and Physical (H&P) dated 12/10/2024, the H&P did not indicate Resident 3's capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 12/13/2024, the MDS indicated Resident 3 was able to understand others and make her needs known had a moderately cognition (having the ability to think, learn, and remember clearly). The MDS indicated Resident 3 requires supervision or touching assistance with eating and oral hygiene; partial/moderate assistance with bed mobility and upper body dressing; substantial/maximal assistance with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 3 was on oxygen therapy on admission and while a resident in the facility. (continued on next page)

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	01/22/2025

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 3's Order Summary Report, the Order Summary Report indicated a physician's order dated 12/10/2024: - Oxygen at two (2) liters per minute (liter/min) via nasal cannula continuously for COPD. During a concurrent observation and interview on 1/18/2025 at 11:59 a.m., inside Resident 3's room with the Infection Preventionist (IP), the IP verified Resident 3's nasal cannula tubing was touching the floor. The IP stated if the nasal cannula tubing was too long and had the potential to touch the floor, the extra tubing should be placed inside the plastic storage bag hanging on the oxygen concentrator. The IP stated Resident 3's nasal cannula tubing have been kept off the floor and the extra tubing hanging should have been placed inside the storage bag as the floor was contaminated and placed Resident 3 at risk for acquiring infection from a contaminated tubing. During an interview on 1/21/2025 at 4:00 p.m. with the Director of Nursing (DON), the DON stated all nasal cannula and nebulizer tubing should be kept off the floor and placed inside the plastic storage bag if too long and/or when not in use. The DON stated Resident 3's nasal cannula tubing should have been kept off the floor at all times and the extra tubing hanging placed inside the plastic storage bag as it placed Resident 3 at risk from acquiring infection due to contaminated tubing touching the floor. During a review of the facility's policy and procedure (P&P) titled, Departmental (Respiratory Therapy) - Prevention of Infection, last reviewed on 7/30/2024, the P&P indicated to change the oxygen cannula and tubing every seven (7) days or as needed and keep in a plastic bag when not in use to prevent infection associated with respiratory therapy task and equipment among residents and staff. During a review of the facility P&P titled, Policies and Practices - Infection Control, last reviewed 7/30/2024, the P&P indicated the facilities infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. All personnel will be trained on the infection control policies and practices upon hire and periodically thereafter.