POC accepted 06/19/2018

36332 PRINTED: 05/31/2018
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	C 05/23/2018

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 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an investigation of a complaint. Complaint Number: CA00575949 Representing the California Department of Public Health: Health Facilities Evaluator Nurse: 36332 The inspection was limited to the specific complaint and does not represent the findings of a full inspection of the facility. A deficiency was written for Complaint Number: CA00575949.	F 000	By submitting this POC, Valley Palms Care Center does not admit or concede the facts and contentions cited, or the existence or scope and severity of the deficiencies and conditions cited in the 2567. The POC is submitted to comply with Federal and State law. Valley Palms Care Center respects the allegations made in the 2567 and have acted and will continue to act to implement this POC.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to meet professional standards of quality by failing to 1. Administer Vancomycin (an antibiotic used to treat infections) as ordered by the physician, after the Vancomycin trough (a blood test done 30 minutes prior to medication administration to determine the lowest level or concentration at which a medication is present in the body, used for therapeutic drug monitoring) was drawn.	F 658	**-How corrective action(s) will be accomplished for those residents found to have been affected.** Resident #1 was monitored for adverse reactions during Vancomycin IV administration and none noted. The RN who signed administration of ITMR on 2/7/18 at 930pm for Vancomycin 1gram IV Q8H is no longer employed at this facility.	6/8/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE ADMINISTRATOR (X6) DATE 6/8/2018

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.

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F 658	Continued From page 1 2. Clarify physician order for Vancomycin and transcribed clarified orders in the physician order form not in the nurse progress notes. These deficient practices resulted in Resident 1 not receiving the therapeutic dose for the treatment of osteomyelitis (infection in a bone) for one of three sampled residents (Resident 1). Findings: a. A review of the Admission Face Sheet indicated Resident 1 was admitted to the facility on 2/6/18 with diagnoses of osteomyelitis on sacral (large, triangular bone at the base of the spine) area and sepsis (potentially life-threatening complication of an infection, occurs when chemicals released into the bloodstream to fight the infection trigger inflammatory responses throughout the body). The Minimum Data Set (an assessment and care screening tool), dated 2/13/18, indicated Resident 1 is alert, required limited assistance during bed mobility, transfer, dressing and personal hygiene and extensive assistance with toilet use and bathing with one person physical assistance. During a review of the Intravenous (IV-administered into a vein) Therapy Care Plan for Resident 1 dated 2/6/18, indicated Resident 1 requires IV therapy of Vancomycin for osteomyelitis. The care plan approaches included to infuse the medication as ordered, observe for possible untoward reactions to the medicine, assess and document the progress of the therapy and notify the physician if it appears the treatment is not effective.	F 658	**-How facility will identify other resident's having potential to be affected and corrective action** Other residents who may be affected by this deficient practice were assessed. No other resident identified to be affected by the same deficient practice. **- Measures/systematic changes facility will make to ensure the deficient practice does not recur.** Registered Nurses were in-serviced on 5/23/18, 5/28/18, 6/2/18 and 6/6/18, regarding administering IV medications with emphasis on Vancomycin IV, and Vancomycin peak and trough levels. Licensed nurses in-serviced on 5/23/18, 5/28/18, 6/2/18, 6/6/18, 6/7/18 and 6/8/18, regarding clarification of physician orders and transcribing clarified orders.	6/8/18 6/8/18

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F 658	Continued From page 2 During a review of the Physician's Order for Resident 1 dated 2/6/18 at 9:48 p.m. indicated to administer Vancomycin one gram IV every eight hours (7:00 a.m., 3:00 p.m. and 11:00 p.m.) and to check Vancomycin trough 30 minutes before the fourth dose (on 2/7/18 at 10:30 p.m.). During a review of the IV Therapy Medication Record (ITMR) for Resident 1, dated 2/7/18 indicated Vancomycin one gram was administered IV at 9:30 p.m. During a review of the Vancomycin trough result for Resident 1 dated 2/8/18 indicated Vancomycin trough was done on 2/7/18 at 10:30 p.m. with a result of 21.4 (high). The Vancomycin trough normal range is 10.0 to 20.0 microgram per milliliter (mcg/ml). During an interview with the Director of Nursing (DON) on 3/6/18 at 9:30 a.m. she stated Vancomycin one gram should have been administered on 2/7/18 as ordered by the physician at 11:00 p.m. and not at 9:30 p.m. The DON further stated the blood test for Vancomycin trough should have been done first on 2/7/18 as ordered at 10:30 p.m. prior to administering Vancomycin IV if not it would yield an inaccurate (usually high) Vancomycin level result and may lead to improper Vancomycin dosing by the pharmacist. b. Further review of the Physician's Order for Resident 1 dated 2/8/18 at 6:09 p.m. indicated to administer Vancomycin 1.25 gram (from one gram) IV every 12 hours (9:00 a.m. and 9:00 p.m.) and to check the Vancomycin trough on 2/10/18 at 8:30 p.m.	F 658	The Director of Nursing/Designee will monitor compliance five times a week to ensure residents receive Vancomycin IV as ordered, and Vancomycin IV orders are clarified and transcribed appropriately. Any non-compliance issues will be reported to Administrator/Designee for follow up. **-How facility plans to monitor performance to ensure solutions sustained.** Medical Records Director/Designee wil confirm compliance when Vancomycin IV is ordered by reviewing orders and administration records weekly. Any non-compliance issue will be reported to Director of Nursing/Designee for follow up. The Director of Nurses/Designee will report findings to the QA Committee monthly for further review and evaluated for its effectiveness for three months or until compliance achieved.	6/8/18

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F 658	Continued From page 3 During a review of the ITMR for Resident 1 dated 2/8/18, indicated Vancomycin one gram was administered IV at 11:00 p.m. During a review of the Vancomycin trough result for Resident 1, dated 2/10/18 at 8:30 p.m. indicated a result of 7.8 (low). The Vancomycin trough normal range is 10.0 to 20.0 mcg/ml. During a review of Nurses Progress Notes dated 2/8/18 at 6:14 p.m. indicated, the pharmacist called and discontinued Vancomycin one gram and Vancomycin 1.25 gram IV every 12 hours to start on 2/9/18. However, this was not clarified to the attending physician and was not transcribed as a physician order. During an interview and record review with the DON on 3/6/18 at 9:40 a.m., she was unable to find clarified physician order indicating Vancomycin 1.25 gram IV every 12 hours to start on 2/9/18. c. During a review of the Physician's Order for Resident 1 dated 2/11/18 at 9:37 a.m. indicated to administer Vancomycin 800 milligrams (mg) (from 1.25 gram) IV every eight hours (6:00 a.m., 2:00 p.m. and 10:00 p.m.) until last dose on 2/13/18. No further Vancomycin trough needed. During a review of the ITMR for Resident 1 dated 2/11/18 indicated Vancomycin 1.25 gram was administered IV at 9:00 p.m. During a review of Nurses Progress Notes dated 2/11/18 at 9:39 a.m. indicated, received new orders from the pharmacist and discontinued Vancomycin 1.25 gram and Vancomycin 800 mg	F 658		

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F 658	Continued From page 4 IV every eight hours to start 2/12/18. However, this was not clarified again to the attending physician and was not transcribed as a physician order. During an interview and record review with the DON on 3/6/18 at 9:45 a.m., she was unable to find clarified physician order indicating Vancomycin 800 mg IV every 12 hours to start on 2/12/18. The DON further stated the licensed nurse should have clarified and transcribed the physician order indicating when the ordered medication should be started. The facility policy and procedure titled "Administering Medications" dated 12/2012, indicated medications must be administered in accordance with the orders, including any required time frame. Another facility policy and procedure titled "Medication Orders" dated 4/2008, indicated medications are administered only upon the clear, complete and signed order of a person lawfully authorized to prescribe. The prescriber is contacted to verify or clarify an order and if the order is from a prescriber other than the attending physician, the order is verified with the current attending physician.	F 658		