SECTION 1424 NOTICE

CITATION NUMBER: 92-0539-0011838-S

Date: 12/14/2015 Time: __________

Type of Visit :

YOU ARE HEREBY FOUND IN VIOLATION OF APPLICABLE CALIFORNIA STATUTES AND REGULATIONS OR APPLICABLE FEDERAL STATUTES AND REGULATIONS

Incident/Complaint No.(s) : CA00412160, CA00412160, CA00412160

Licensee Name: Verdugo Valley Skilled Nursing & Wellness Centre, LLC
Address: 2635 Honolulu Ave. Montrose, CA 91020-1706
License Number: 920000044 Type of Ownership: Limited Liability Company

Facility Name: VERDUGO VALLEY SKILLED NURSING & WELLNESS CENTRE
Address: 2635 Honolulu Ave Montrose, CA 91020
Telephone: (818) 248-6856
Facility Type: Skilled Nursing Facility Capacity: 138
Facility ID: 920000027

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS	PENALTY ASSESSMENT $10,000.00	DEADLINE FOR COMPLIANCE 12/14/15 5:00 p.m.
1424(f)	**CLASS** WMF **CITATION -- PATIENT RECORD**		

California Health & Safety Code
1424 (f)
(1) Any willful material falsification or willful material omission in the health record of a patient of a long-term health care facility is a violation.

(2) "Willful material falsification," as used in this section, means any entry in the patient health care record pertaining to the administration of medication, or treatments ordered for the patient, or pertaining to services for the prevention or treatment of decubitus ulcers or contractures, or pertaining to tests and measurements of vital signs, or notations of input and output of fluids, that was made with the knowledge that the records falsely reflect the condition of the resident or the care or services provided.

(3) "Willful material omission," as used in this section, means the willful failure to record any untoward event that has affected the health, safety, or security of the specific patient, and that was omitted with the knowledge that the records falsely reflect the condition of the resident or the care or services provided.

Name of Evaluator:
Martha Chapin
RN, HFE III

Evaluator Signature : ______________________

Without admitting guilt, I hereby acknowledge receipt of this SECTION 1424 NOTICE

Signature : ______________________
Name : ______________________
Title : ______________________

NOTE: IN ACCORDANCE WITH CALIFORNIA HEALTH AND SAFTEY CODE, FAILURE TO CORRECT VIOLATIONS IS GROUNDS FOR SUSPENSION OR REVOCATION OF YOUR LICENSE

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	The facility staff willfully falsified Resident 1's medical records by documenting physicians' orders which were not given by Physician 3, or any other physician that could be identified, from June 2013 to June 2014. As a result, Resident 1 was not under the care of a primary physician for over a year. During an unannounced complaint investigation (Entity Reported Incident CA00412160) to the facility that exited on November 4, 2015, it was determined that the medical record falsely reflected the care and services provided to Resident 1. Physician 3, who was listed as Resident 1's primary physician, never visited the resident in the facility and never wrote or called orders for the resident's care. The Physician Admission Orders dated June 3, 2013 at 8:40 p.m., indicated Physician 3 as the primary physician. The orders included diagnoses, diet, medication, and treatment including rehab screen for physical, occupational and speech therapy. The orders were never reviewed or signed by Physician 3 but, there was an unidentified signature which was not dated. The orders were received by Registered Nurse (RN) 5 but it was not known who gave the orders. The following Physician's and Telephone Orders were not signed by a physician: On November 26, 2013, at 3 p.m., an order to discontinue the medication zinc was written by Licensed Psychiatric Tech (LPT) 1. The order indicated it was Physician 3/LPT 1's order; On January 20, 2014, an order to discontinue high protein nourishment between meals was written by Licensed Vocational Nurse (LVN) 4. The order indicated it was a Telephone Order (TO) from Physician 3; On March 8, 2014, an order to discontinue Tylenol was written by LVN 3. It was documented as a TO from Physician 3; On April 5, 2014 at 6:00 p.m., an order was written to readmit Resident 1, to continue previous orders and medications, and Levaquin 500 milligrams daily times 10 days. There was no documentation to indicate who gave the order but Physician 3's name was listed as the attending physician;

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	On April 6, 2014, at 11 a.m., a TO for the treatment of a forehead skin abrasion was written by LVN 3; On April 6, 2014, at 2:00 p.m., a TO was written by Licensed Psychiatric Tech (LPT) 1 to send Resident 1 to the acute hospital emergency room for head computed tomography (CT) scan due to fall; On April 8, 2014, at 10 p.m., a TO for treatments of a forehead abrasion, left and right buttocks Stage I pressure sores were written by LVN 2; On April 9, 2014, an order was written for AAROM (Active aggressive range of motion) bilateral upper extremity daily and PROM (Passive range of motion) to digits and bilateral resting hand splints times two hours as tolerated. This TO was taken by rehab staff; and On May 15, 2014, a clarification of order was written by LVN 7. The order indicated Physician 3 as the attending physician. The Multidisciplinary Progress Notes indicated the following: On July 3, 2013, at 1 p.m., Physician 3 and PA 1 aware of Resident 1's weight gain. It could not be determined who PA 1 was, as Physician 3 never saw Resident 1; On July 12, 2013, at 12 noon, it was documented "the physician" was notified of 10 pounds weight gain and the physician stated beneficial weight gain; On July 21, 2013, at 8 p.m., Physician 3 was called regarding Resident 1's pain medication; On November 22, 2013, at 10 p.m., it was documented the physician did not want to change the order per pharmacy request. It did not identify the physician contacted; On March 25, 2014, at 1:30 p.m., it was documented that Resident 1 was seen and examined by Physician 1 with no new order; On April 5, 2014 at 9:15 a.m., an order was received to transfer Resident 1 to the GACH with no indication who ordered the transfer. At 6 p.m., it was documented that Resident

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	1 was readmitted to the facility and Physician 3 was notified, reported the new order and approved of it. Physician 3 was never Resident 1's physician in the SNF; The Physician's Pressure Sore Progress Notes dated June 3, 2013, July 3, 2013 and August 3, 2013, were filled out with Physician 3's name printed on the form as the physician; the notes were never signed by a physician; The Physician Psychotherapeutic Intervention Progress Notes dated June 7, 2013, July 7, 2013, August 7, 2013, September 6, 2013, October 7, 2013, November 7, 2013, December 6, 2013, January 6, 2014, February 6, 2014, and March 5, 2014, were pre-printed and filled out but never signed; and The Interdisciplinary Team (IDT) Conference Record held on April 9, 2014, indicated staff discussed with the physician regarding Resident 1's treatment plan without any changes made with the plan of care. The resident had no physician assigned. The IDT also indicated to monitor for any significant functional changes and refer to the physician. On July 8, 2015, documents were reviewed from the Department of Justice (DOJ), Bureau of Medical Fraud & Elder Abuse Unit. They conducted interviews with Physician 3, informing him that according to the records at the facility, he was listed as the primary care physician from the first day Resident 1 was admitted on June 3, 2013, through June 2014. Physician 3 indicated he was never Resident 1's physician at the facility, he was not associated with the facility and should never have been listed as Resident 1's physician in their records. Physician 3 stated he never went to the facility. On September 28, 2015, at 4 pm, during a phone interview with Physician 3, he stated Resident 1 was not his patient, and that he had never been to the involved facility as it was not in his geographical area. On October 2, 2015, at 11:20 a.m., licensed vocational nurse (LVN) 2 stated in an interview that initial treatment orders were written by the treatment nurse or charge nurse and communicated to the doctor assigned. LVN 2 wrote a treatment order but could not remember that he talked to the physician. He stated he left a message for the physician, and because it was a treatment order, he went ahead and did the treatment. On October 2, 2015, at 12:05 p.m., RN 3 stated in an interview that when a resident was admitted, there was already an admission package completed with the physician's

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	name. RN 3 stated the initial order came from the hospital, was followed, and the primary physician was informed of the admission. RN 3 stated she did a recap order for Resident 1 which was to check the medications ordered. On October 2, 2015, at 1:20 p.m., in an interview with the Physical Therapy Director, he stated the rehab staff writes the treatment order, and the charge nurse calls the physician. On October 2, 2015 at 2:10 p.m., during an interview with the Director of Nurses, she stated the nursing staff does not call the physician for rehab orders. She stated if the orders were for rehab, the rehab staff should be calling the physician. On October 27, 2015, at 1:15 p.m., during a phone interview with the Admissions Coordinator (AC), she stated she remembered Resident 1 but have no idea who Physician 3 was. She stated that on many occasions the hospital's discharge planner give her the name of the physician who will follow-up on the resident in the facility. The AC stated she took the inquiry and gave it to the DON for her approval. When the DON approved the admission, AC then called the hospital to tell them the resident will be admitted. At 4:00 p.m., during a telephone interview with LVN 8, he stated he could not remember if he had talked to Physician 3as he had never seen him in the facility. With the TO, he stated that if the primary physician was not available, he would called the Medical Director. He also stated he was pretty sure he talked to Physician 3 if he had written it in the medical record. On November 5, 2015, at 1:50 p.m., during a phone interview with Physician 1, he stated when he was informed about Resident 1's request to change physicians, he visited the next day, June 3, 2014. Physician 1 stated he could not recall talking to the facility staff regarding Resident 1 prior to the day he was informed, June 2, 2014. The facility staff willfully falsified Resident 1's medical records by documenting physicians' orders which were not given by Physician 3, or any other physician that could be identified, from June 2013 to June 2014. As a result, Resident 1 was not under the care of a primary physician for over a year. Failure of the facility to accurately document who gave the physician's order had a direct or immediate relationship to the health and safety of Resident 1.

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