

Department of SOCIAL SERVICES

Community Care Licensing

FACILITY EVALUATION REPORT

Facility Number: 197603165
Report Date: 11/09/2021
Date Signed: 11/09/2021 10:39:54 AM

Document Has Been Signed on 11/09/2021 10:39 AM - It Cannot Be Edited

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY	CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING DIVISION CCLD Regional Office, 21731 VENTURA BLVD. #250 WOODLAND HILLS, CA 91364
FACILITY EVALUATION REPORT	

FACILITY NAME: GLEN PARK AT VALLEY VILLAGE	FACILITY NUMBER: 197603165
ADMINISTRATOR: PINK TILLMAN	FACILITY TYPE: 740
ADDRESS: 5527 LAUREL CANYON BLVD	TELEPHONE: (818) 769-6626
CITY: VALLEY VILLAGE	STATE: CA
CAPACITY: 100	ZIP CODE: 91607
TYPE OF VISIT: Case Management - Incident	CENSUS: 33
MET WITH: Tillman Pink	DATE: 11/09/2021
	UNANNOUNCED TIME BEGAN: 10:15 AM
	TIME COMPLETED: 10:45 AM

NARRATIVE	
1	On November 9, 2021, Licensing Program Analyst (LPA) Ashley Smith met with Executive Director
2	Tillman Pink for a Case Management visit to issue a civil penalty per Health and Safety (H&S) Code
3	§1569.49.
4	
5	On September 10, 2017, the Department received two incident reports from Glen Park at Valley Village.
6	The first incident report stated that an 83-year old male resident (R1) was hospitalized on September 7,
7	2017 due to difficulty breathing and unresponsiveness. The second incident report stated that on
8	September 10, 2017, administrators verified that the medication technician (S2) admitted to a
9	medication error. On September 15, 2017, the Department received a death report from Glen Park at
10	Valley Village reflecting that R1 passed away on September 13, 2017.
11	
12	The Department conducted an investigation which revealed that on the morning of September 7, 2017,
13	staff 1 (S1), whom was not trained in assisting residents with the self-administration of medications,
14	placed Resident 2's (R2) medications on a dining room table between R1 and R2. R2 was prescribed 12
15	medications. The following are medications with possible adverse effects (harmful or undesirable
16	effects) which could have contributed to R1's sudden change in condition:
17	
18	
19	
20	1. Duloxetine HCL 30 mg (antidepressants, neuropathic pain agent) - myocardial infarction, GI bleeding,
21	nausea, vomiting, dizziness, lethargy, syncope, hypotension)
22	2. Clonazepam 0.5 mg (benzodiazepines, antianxiety) - coma, dyspnea, chest pain, palpitations,
23	respiratory depression, drowsiness, dizziness)
24	3. Divalproex Sodium 500 mg (anticonvulsants, mood stabilizers) - coma, irregular heartbeat, chest
25	pain, palpitations, hypotension, drowsiness, nausea, vomiting, dizziness, lethargy)
	4. Benzotropine 1 mg (anticholinergic, antispasmodic) - delirium, psychosis, drowsiness, dizziness
	5. Clozapine 100 mg (antipsychotics) – seizures, irregular heartbeat, stroke, atrial fibrillation, cardiac
	arrest, hypertension, delirium, dizziness, syncope
	(Classifications and side effects listed. Pdr.net – medication reference used)

NAME OF LICENSING PROGRAM MANAGER: Jeralyn Ann Pfannenstiel

NAME OF LICENSING PROGRAM ANALYST: Ashley Smith

LICENSING PROGRAM ANALYST SIGNATURE:



DATE: 11/09/2021

I acknowledge receipt of this form and understand my licensing appeal rights as explained and received.

FACILITY REPRESENTATIVE SIGNATURE:



DATE: 11/09/2021

This report must be available at Child Care and Group Home facilities for public review for 3 years.

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION
CCLD Regional Office, 21731 VENTURA BLVD.
#250
WOODLAND HILLS, CA 91364

FACILITY EVALUATION REPORT (Cont)

FACILITY NAME: GLEN PARK AT VALLEY VILLAGE

FACILITY NUMBER: 197603165

VISIT DATE: 11/09/2021

NARRATIVE

- 1 R1's regular prescribed medications were Hydrocodone (opioid for moderate to severe pain) Doc-Q-lace
- 2 (stool softener), Pantoprazole (proton pump inhibitors), and Prednisone (corticosteroids).
- 3
- 4 According to interviews, S1 witnessed R1 ingest R2's medications and reported the medication error to
- 5 S2 only. S2 admitted to not reporting the incident to any administrative staff, but advised S1 to closely
- 6 monitor R1 every 30 minutes. Staff also reported R1 did not leave R1's room at lunch time. On
- 7 September 8, 2017, the administrator (S3) heard a rumor that S1 and S2 may have been responsible for
- 8 R1's hospitalization. On September 10, 2017, S3 and the assistant administrator (S4) interviewed S1
- 9 and S2, who admitted to the medication error.
- 10
- 11 On September 7, 2017, R1 was found breathing, but unresponsive in his room. When staff, S5 and S6,
- 12 tried to sit R1 up, he began vomiting and emergency response was called. According to medical reports,
- 13 R1 was admitted to the hospital on September 7, 2017 at 4:41 p.m. with acute encephalopathy and
- 14 presumed sepsis of unknown etiology. He was given 2 mg of Narcan, which improved his respiratory
- 15 rate. Upon learning of the medication error, S3 informed the hospital on September 10, 2017. The
- 16 Associate Medical Director of Palliative Medicine stated in her progress note that it appeared "*the*
- 17 *patient's altered mental status and respiratory failure were due at least in part to the medication error*
- 18 *(multiple drug-drug interactions with CNS and respirator depression and other potential adverse effects.*"
- 19 Per Mayo Clinic, sepsis is a "*potentially life-threatening complication of an infection, and occurs when*
- 20 *chemicals released into the bloodstream to fight the infection trigger inflammatory responses throughout*
- 21 *the body. This inflammation can trigger a cascade of changes that can damage multiple organ systems,*
- 22 *causing them to fail.*" R1's family requested comfort measures only due to R1's (Do Not Resuscitate/Do
- 23 Not Intubate (DNR/DNI) order. R1 expired on September 13, 2017 at 6:07 p.m., and an autopsy was
- 24 performed. According to the autopsy report dated September 21, 2017, R1's official cause of death was
- 25 acute bronchopneumonia with coronary artery atherosclerosis, nephrosclerosis, and medication toxicity.
- 26
- 27 On September 11, 2017 at approximately 1:30 p.m a case management visit was conducted and the
- 28 Licensee was cited for Title 22 California Code of Regulations (22 CCR) § 87411(a) Personnel
- 29 Requirements - General which states, "*Facility personnel shall at all times be sufficient in numbers, and*
- 30 *competent to provide the services necessary to meet resident needs.*"
- 31
- 32

NAME OF LICENSING PROGRAM MANAGER: Jeralyn Ann Pfannenstiel

NAME OF LICENSING PROGRAM ANALYST: Ashley Smith

LICENSING PROGRAM ANALYST SIGNATURE:

DATE: 11/09/2021

I acknowledge receipt of this form and understand my licensing appeal rights as explained and received.

FACILITY REPRESENTATIVE SIGNATURE:

DATE: 11/09/2021

FACILITY EVALUATION REPORT (Cont)**FACILITY NAME:** GLEN PARK AT VALLEY VILLAGE**FACILITY NUMBER:** 197603165**VISIT DATE:** 11/09/2021**NARRATIVE**

1 On September 15, 2017 at approximately 3:30 p.m., the Licensee was cited for Title 22 CCR § 87465(g)
 2 Incidental Medical and Dental Care Services which states, "9-1-1 shall be telephoned immediately if an
 3 injury or other circumstance has resulted in an imminent threat to a resident's health, including an
 4 apparent life-threatening medical crisis." Additionally, § 87465(h)(2) Incidental Medical and Dental Care
 5 Services was cited which states, "Centrally stored medications shall be kept in a safe locked place that
 6 is not accessible to persons other than employees responsible for the supervision of the medication."
 7
 8 Today, on November 9, 2021 an additional citation is issued under Health & Safety (H&S) Code
 9 §1569.69(a)(1) Employees assisting residents with self-administration of medication; training
 10 requirements which states, "Each residential care facility for the elderly licensed under this chapter shall
 11 ensure that each employee of the facility who assists residents with the self-administration of
 12 medications meets all of the following training requirements: (1) In facilities licensed to provide care for
 13 16 or more persons, the employee shall complete 24 hours of initial training. This training shall consist of
 14 16 hours of hands-on shadowing training, which shall be completed prior to assisting with the self-
 15 administration of medications, and 8 hours of other training or instruction, as described in subdivision (f),
 16 which shall be completed within the first four weeks of employment."
 17
 18 On September 15, 2017, the licensee was informed that a civil penalty of \$15,000 might be assessed
 19 based on H&S Code §1569.49. The Department has concluded an analysis and has determined that a
 20 civil penalty is warranted for a violation resulting in a resident's death. This is evidenced by facility staff
 21 failure to complete all required medication training prior to assisting residents with the self-administration
 22 of medications, and staff's failure to immediately telephone 9-1-1 and inform medical professionals of
 23 the medication error which led to the hospitalization and death of R1.
 24
 25 Exit interview conducted. A copy of the report issued. Appeal rights provided. Mr. Pink's signature on this
 26 report acknowledges receipt of these rights, found on page 2 of LIC 421D.
 27
 28
 29
 30
 31
 32

NAME OF LICENSING PROGRAM MANAGER: Jeralyn Ann Pfannenstiel**NAME OF LICENSING PROGRAM ANALYST:** Ashley Smith**LICENSING PROGRAM ANALYST SIGNATURE:****DATE:** 11/09/2021

I acknowledge receipt of this form and understand my licensing appeal rights as explained and received.

FACILITY REPRESENTATIVE SIGNATURE:**DATE:** 11/09/2021**Document Has Been Signed on 11/09/2021 10:39 AM - It Cannot Be Edited****Created By: Ashley Smith On 11/09/2021 at 09:02 AM****Link to Parent Document Below:****FACILITY EVALUATION REPORT (Cont)****FACILITY NAME:** GLEN PARK AT VALLEY VILLAGE**FACILITY NUMBER:** 197603165**DEFICIENCY INFORMATION FOR THIS PAGE:****VISIT DATE:** 11/09/2021

Deficiency Type POC Due Date / Section Number	DEFICIENCIES	PLAN OF CORRECTIONS(POCs)	

<p>Type A 11/09/2021 Section Cited</p>	<p>1 1569.69(a)(1) Employees assisting 2 residents with self-administration of 3 medication; training requirements. ... 4 The employee shall complete 24 5 hours of initial training. ...16 hours of 6 hands-on shadowing training... and 8 7 hours of other training or instruction ... This requirement is not met as evidenced by:</p>			
	<p>8 Based on the investigation, the 9 licensee did not comply with the 10 section cited above, as staff failed to 11 complete all required medication 12 training prior to assisting residents 13 with the self-administration of 14 medication for R1, which poses an immediate health and safety risk to residents in care.</p>	<p>8 9 10 11 12 13 14</p>		
	<p>1 2 3 4 5 6 7</p>			
	<p>1 2 3 4 5 6 7</p>			

Failure to correct the cited deficiency(ies), on or before the Plan of Correction (POC) due date, may result in a civil penalty assessment.

<p>SUPERVISOR'S NAME: Jeralyn Ann Pfannenstiel</p> <p>LICENSING EVALUATOR NAME: Ashley Smith</p> <p>LICENSING EVALUATOR SIGNATURE:</p>	
	<p>DATE: 11/09/2021</p>
<p>I acknowledge receipt of this form and understand my appeal rights as explained and received.</p>	
<p>FACILITY REPRESENTATIVE SIGNATURE:</p>	
	<p>DATE: 11/09/2021</p>