STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555726	A. BUILDING _____ B. WING _____	07/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRY VILLA MAR VISTA NRS CT	3966 MARCASEL AVE LOS ANGELES, CA 90066

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 0684 **Level of harm -** 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** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), who was assessed at risk for weight loss and required extensive assistance with eating, received care and services in accordance with the comprehensive assessment and plan of care. The facility failed to: 1. Monitor Resident 1 for dehydration (condition caused by the loss of too much fluids from the body, for the body functions to work properly) signs and symptoms (thirst, dry mouth, urinating less than usual, dark-colored urine, dry skin, and dizziness) via intake and output log, 2. Refer Resident 1 to Dietary Manager or for Registered Dietitian (RD) consult to assess nutrition and hydration as needed. These deficient practices resulted in Resident 1 having a change in condition (a decline in Activities of Daily Living -ADL, and a loss of appetite), requiring transfer to General Acute Care Hospital 1 (GACH 1) on [DATE] for further evaluation, where she was diagnosed with [REDACTED]. Resident 1 expired at GACH 1 two days later [DATE]. Findings: A review of the Admission Record (face sheet) indicated Resident 1 was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of the Quarterly Nutritional Evaluation form dated [DATE], indicated the Dietary Manager did not conduct timely quarterly nutritional evaluations for Resident 1. The quarterly form indicated several evaluations were conducted late or missing. There was no evaluation conducted for [DATE] or [DATE]. A review of Resident 1's Care Plan on Nutrition and Hydration, updated [DATE], indicated Resident 1 was at risk for weight loss due to a history of weight loss, dysphagia (difficulty swallowing), and poor appetite. The interventions included maintaining intake (what the person takes in including fluids and food) and output (fluid voided) log as indicated, monitoring for signs and symptoms of dehydration, notifying the physician, referring resident for dietary consult, and the RD to assess nutrition and hydration as needed. According to a review of the Activities Daily Living (ADLs) Flowsheet dated ,[DATE] Resident 1 was eating ,[DATE] % of meals. A review of Resident 1's Minimum Data Set (MDS - standardized assessment and tool), dated [DATE], indicated Resident 1 had a clear speech, difficulty communicating, and required extensive assistance from staff with eating, dressing, and personal hygiene. A review of Resident 1's Change of Condition notes dated [DATE], timed at 12:45 p.m., indicated Resident 1 had a decline in ADLs and a loss of appetite. The note did not address notification to the Dietary Manager or RD for evaluation and recommendations. A review of Resident 1's Licensed Personnel Weekly Progress Note, dated [DATE], for the 3 p.m. to 11 p.m. shift, indicated Resident 1 was monitored for a decline in ADLs, loss of appetite, and Resident 1 had eaten about 40% of the meal. There was no further documentation related to Resident 1's change of condition for the next 40 hours, on [DATE] for the 11 p.m. to 7 a.m. shift; on [DATE] for the 7 a.m. to 3 p.m., 3 p.m. to 11 p.m., and 11 p.m. to 7 a.m. shifts; and on [DATE] for the 7 a.m. to 3 p.m. shift. According to a review of Resident 1's ADLs Flowsheet dated [DATE], Resident 1 refused breakfast and lunch. There was not documentation substitutes or alternative meal was offered. A review of Resident 1's Speech Therapy Evaluation and Plan of Treatment, dated [DATE], indicated Resident 1 had poor oral intake and was recommended swallowing evaluation to assess the swallowing function and determine the need for a least restrictive diet. Resident 1 was unable to cooperate and exhibited limited alertness for exam. A review of Resident 1's ADLs Flowsheet dated [DATE], indicated Resident 1 refused dinner and refused the substitute or alternative meal offered. According to a review of Resident 1's Licensed Personnel Weekly Progress Note dated [DATE], Resident 1 had a decrease in appetite. The ADLs Flowsheet did not include Resident 1's fluid intake or output. There was no other record to indicate the intake and output was monitored. A review of Resident 1's radiology and laboratory report dated [DATE], indicated a chest Xray with [MEDICAL CONDITION] congestion. Resident 1's sodium level (an essential electrolyte that helps maintain the balance of water in and around your cells) was elevated at 178 (normal level ,[DATE] milliequivalents per liter (mEq/L). The [MEDICATION NAME] level (protein needed to keep growing and repairing tissues) was 3.1 (normal level 3.4 - 5.4 grams per deciliters- g/dL). Resident 1's oxygen saturation (the amount of oxygen-saturated the red blood carry for the proper functioning of the different organs) was 80% (normal is above 95%). A review of Resident 1's physician's orders [REDACTED]. A review of the GACH 1's ED Physical Examination, dated [DATE], indicated Resident 1 appeared chronically ill and cachectic (a physical wasting with loss of weight and muscle mass). A review of the GACH's History and Physical (H&P) note, dated [DATE], indicated Resident 1 was severely dehydrated, severe temporal wasting, mucous membranes dry, and five second skin tenting (a delay in the return of pinched skin to a flat position, after it has been tugged, elevated above the rest of the skin and released, which indicates dehydration). The laboratory results indicated Resident 1 had an abnormal elevated sodium ([MEDICAL CONDITION] - common causes are insufficient fluid intake and too much water loss) level of 177 mEq/L (normal range between 135 and 145 mEq/L) and an abnormal [MEDICATION NAME] (a blood protein that makes up a significant portion of the blood plasma. Plasma is the liquid portion of the blood that holds the proteins and blood cells) level of 2.9 g/dL (normal range 3.4 to 5.4 g/dL) suggesting malnutrition. According to a review of Resident 1's GACH 1's Critical Care Physician Consultants' Notes, dated [DATE], Resident 1 had severe malnutrition, acute kidney injury and hypoxic (not having enough oxygen in the blood) [MEDICAL CONDITION]. A review of Resident 1's GACH 1's Discharge Summary Note, dated [DATE] indicated Resident 1 expired on [DATE]. During an interview with the Dietary Manager, on [DATE] at 1:11 p.m., she stated she did not do the quarterly nutritional evaluation for Resident 1 every four months (quarterly). During an interview, on [DATE], at 8:45 a.m., Licensed Vocational Nurse 3 (LVN 3) stated staff should monitor residents for 72 hours after a change of condition and document in the nursing notes as per facility's policy. LVN 3 stated if the change of condition was related to a loss of appetite, the Dietary Manager would be notified. During an interview with RD 1 on [DATE], at 11:45 a.m., RD 1 stated she was not notified of Resident 1's loss of appetite and would have assessed the resident if made aware. During an interview on [DATE], at 12:20 p.m., Registered Nurse 1 (RN 1) stated Resident 1 should have been monitored for 72 hours or until the problem was resolved. RN 1 stated each nursing shift should have documented their findings related to Resident 1's loss of appetite in the Licensed Nurse's Progress Notes. RN 1 further stated, Resident 1 may have weight loss and weakness if staff failed to monitor/assess and document. During an interview with the Dietary Manager, on [DATE], at 12:30 p.m., the Dietary Manager stated she was not notified of Resident 1's change of condition regarding a loss of appetite. The Dietary Manager further stated if she was made aware of Resident 1's loss of appetite she would have notified the Registered Dietitian. During an interview with RN 1 on [DATE] at 12:50 p.m., after reviewing Resident 1's clinical record, RN 1 confirmed there was no referral to RD, nursing staff were not measuring the fluids intake and output, there was no monitoring every shift during the 72-hour period after the change of condition. RN 1 failed to provide additional documentation after numerous requests. During interview with the Director of Nursing (DON) on [DATE] at 1:30 p.m., she stated it was not necessary for Resident 1 to have intake and output documented. However, Resident 1's care plan interventions indicated to maintain intake and output log. The facility policy and procedure titled, Change of Condition Notification, dated [DATE], indicated a licensed nurse will document each shift for at least seventy-two (72)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555726	A. BUILDING _____ B. WING _____	**07/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRY VILLA MAR VISTA NRS CT	**3966 MARCASEL AVE LOS ANGELES, CA 90066**

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 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) hours. Documentation pertaining to a change in the resident's condition will be maintained in the resident's medical record and on the twenty-four-hour report. The facility policy and procedure titled, Alert Charting Documentation, dated [DATE], indicated the facility will place all newly admitted residents, residents whose condition is unstable, and residents who have a change in their condition on alert charting. Alert charting is required for changes in medical condition, difficulty swallowing, and changes in mental / behavior condition. Licensed nurses on each shift are responsible for assessing residents, including vital signs and documenting the resident's status related to the change of condition. The policy indicated notes pertaining to the change of condition will be maintained in the resident's medical record as narrative notes. The facility policy and procedure titled, Quarterly Nutritional Evaluation and Progress Notes, dated [DATE] indicated the Dietary Manager will complete a quarterly nutritional evaluation for residents to reflect current nutritional needs. Additional documentation of nutritional needs between quarterly evaluations should be documented on the nutritional progress notes. The facility policy and procedure titled, Evaluation of Weight and Nutritional Status, revised [DATE] indicated in connection with the assessments the RD and the Interdisciplinary Team will further assess nutritional needs and goals of the resident within the context of his/her overall condition, including oral intake of foods and fluid.
F 0693 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a 30 degree safe gastrostomy tube ([DEVICE], is the creation of an artificial external opening into the stomach for nutritional support or gastric decompression) feeding position for two of three sampled residents (Residents 2 and 3). These failed practices had the potential to cause aspiration (is when something enters your airway or lungs by accident. It may be food, liquid, or some other material) pneumonia (is an infection that inflames the air sacs in one or both lungs) and impede progress to wellness. Findings: On 5/30/2020 at 10:40 a.m., an unannounced visit was made to the facility to investigate a complaint regarding quality of care. a. A review of the admission record indicated Resident 3 was re-admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 3's Minimum Data Set (MDS - an assessment and care planning tool), dated 4/11/2020, indicated Resident 3 had no speech, rarely the ability to express ideas and wants, and rarely the ability to understand others. The MDS further assessed Resident 3 requiring extensive assistance with bed mobility and dressing, and total dependence on full staff performance for eating. A review of Resident 3's physician's orders [REDACTED]. A review of Resident 3's care plan titled, Nutrition-Tube Feeding, dated 4/9/2020, indicated, a goal of remaining free of complications related to the tube feeding and have minimized signs of aspiration, nausea, vomiting, and diarrhea. The nursing interventions included to check tube placement, keep head of bed elevated during feeding, and administer tube feeding as ordered. During an observation and a concurrent interview with LVN 2, on 5/30/2020 at 11:40 a.m., Resident 3 was lying in bed sleep, with the head of the bed at a 20 degree angle while the [DEVICE] feeding of Glucerna 1.2 calories at 65 ml via pump was on and infusing. LVN 2 stated Resident 3 may aspirated on the feeding. b. A review of Resident 2's care plan titled, Nutrition-Tube Feeding dated 4/9/2020, indicated, a goal of remaining free of complications related to the tube feeding and will have minimized signs of aspiration, nausea, vomiting, and diarrhea. The nursing interventions included to check tube placement, keep head of bed elevated during feeding, and administer tube feeding as ordered. A review of Resident 2's admission record indicated Resident 2 was re-admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of the physician orders [REDACTED]. The enteral order further indicated to elevate the head of the bed to 30 to 45 degrees while tube feeding is on, check for placement and patency every shift. A review of the MDS dated [DATE], indicated Resident 2 had unclear speech, limited ability to making concrete requests, and responds adequately to simple, direct communication only. The MDS further assessed Resident 2 requiring extensive assistance with bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture), dressing, and eating. During a tour of the facility on 5/30/2020 at 10:55 a.m., Resident 2 was observed lying in bed receiving a [DEVICE] feeding of [MEDICATION NAME] 1.2 calories at 50 ml via pump, with the head of the bed at a 20 degree angle. During an observation and a concurrent interview with the Licensed Vocational Nurse (LVN 1), on 5/30/2020, at 10:55 a.m., LVN 1 stated Resident 2 had a potential to choke on the [DEVICE] feeding. LVN 1 repositioned Resident 2 and increased the head of the bed to a 30 degree angle (a safer angle to receive a [DEVICE] feeding). The facility policy and procedure titled, Enteral Feeding - Open, dated January 1, 2012, indicated enteral feeding will be administered via pump as ordered by the attending physician. The policy further indicated the head of the bed should be elevated 30 degrees during feedings, wash hands before and after each procedure, and check resident for tube placement by aspirating stomach content.