STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056031	A. BUILDING _____ B. WING _____	**09/25/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NEW VISTA NURSING AND REHABILITATION CENTER	**8647 FENWICK STREET. SUNLAND, CA 91040**

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** - 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** Based on interview and record review, the facility failed to follow the physician's order to remove the surgical staples (specialized staples used in surgery in place of sutures to close skin wounds) and failed to notify the physician the inability to fully implement the order to remove all the staples for one of three sampled residents (Resident 1). On 9/3/2020, Resident 1's surgical staples from a left hip surgery, were not all removed. There were eight left on the wound because they were painful to remove. This deficient practice had the potential to place Resident 1 at risk for infection on the left hip surgical incision. Findings: A review of Resident 1's Admission Record (Face Sheet) indicated the facility admitted Resident 1 on 8/14/2020 with [DIAGNOSES REDACTED]. A review of Resident 1's Care Plan developed on 8/19/2020 for Resident 1's altered skin integrity, indicated the interventions included to monito intake. A review of Resident 1's Physician's Order dated 8/20/2020 indicated to provide four ounces of health shake (nutritional supplement) three times a days between meals and record amount consumed. A review of Resident 1's Care plan dated 8/19/2020, developed for the resident's altered skin integrity related to surgical wound on left hip and left lateral thigh, indicated in the interventions to notify the physician and the family if any changes or resident's complain of pain or discomfort. A review of Resident's 1 Minimum Data Set (MDS - a standardized assessment and care- screening tool) dated 8/25/2020, indicated the resident was able to communicate needs and make decisions. Resident 1 needed supervision with eating and assistance with bathing, toilet use, and personal hygiene. A review of Resident 1's Physician's Order dated 9/3/2020 indicated to remove the surgical staples to left hip and thigh. A review of Resident 1's Nurses Notes dated 9/3/2020 at 2:40 p.m., a licensed nurse documented receiving the physician's order to remove the staples which was carried out. A review of Resident 1's Nurses Notes dated 9/3/2020 at 8:15 p.m. a licensed nurse documented Resident 1 was monitored after staple removal on left hip and left lateral thigh. Resident 1 did not have pain, bleeding or sign and symptoms of infection. The documentation did not indicate Resident 1 still had staples on the surgical incision. During a telephone interview on 9/14/2020 at 2:45 p.m., Licensed Vocational Nurse 2 (LVN 2) stated on 9/3/2020 he removed eight staples but was not able to remove the remaining eight because they were stuck on Resident 1's skin and Resident 1 was feeling discomfort so he stopped. LVN 2 documented the procedure it in the Treatment Administration Record (TAR) but did not report to the physician, the nurse supervisor, the family, or the incoming shift. On 9/10/2020 at 2 p.m. during an interview, Family Member 1 (FM 1) stated Resident 1 left the faciity on [DATE] against medical advice (AMA). Upon arrival home, FM 1 noticed Resident 1 had still staples on his left hip and the nurses did not notify her about it. During an interview on 9/14/2020 at 3:30 p.m. the Director of Nurses stated licensed nurses had to notify the physician when unable to carry out the order and endorse the situation to the incoming shift. During an interview on 9/15/2020 at 11:30 a.m., LVN 3 stated she was the nurse for Resident 1 on 9/4/2020, when Resident 1 left AMA. LVN 3 stated she was not aware Resident 1 had some staples left on his incision. She verbalized that if she knew, she would have told FM 1 to follow up with the surgeon and monitor the incision for sign and symptoms of infection. A review of the facility's policy on Change of Condition and Care Planning, dated 10/1/2017, indicated all changes in resident's condition will be documented in the medical record and communicated to the physician and resident/responsible party.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure on of three sampled residents (Resident 1) was monitored for consumption of nutritional supplements as ordered by the physician. For Resident 1, who had a nutritional problem and required nutritional supplement drinks, there was no evidence the amount drank was monitored. This deficient practice had the potential to place Resident 1 at risk for weight loss. Findings: A review of Resident 1's Admission Record (Face Sheet) indicated the facility admitted Resident 1 on 8/14/2020 with [DIAGNOSES REDACTED]. A review of Resident 1's Care Plan developed on 8/18/2020 for Resident 1's risk for dehydration and weight loss, the interventions included monitoring intake. A review of Resident 1's physician's orders [REDACTED]. A review of Resident's 1 Minimum Data Set (MDS - a standardized assessment and care- screening tool) dated 8/25/2020, indicated the resident was able to communicate needs and make decisions. Resident 1 needed supervision with eating and assistance with bathing, toilet use, and personal hygiene. A review of Resident 1's physician's orders [REDACTED]. A review of Resident 1's weekly weight dated 8/26/2020, indicated 171 pounds. On 9/2/2020, Resident 1's weight was 167 pounds. On 9/11/2020 at 11:15 a.m., an interview with Licensed Vocational Nurse 1 (LVN 1) and the Director of Nursing (DON) and a concurrent review of the Medication Administration Record [REDACTED]. The Ensure Plus amount consumed was not recorded in the MAR. LVN 1 stated the nutritional supplements intake should be documented in the MAR. The DON confirmed the licensed nurses were not documenting Resident 1's intake as ordered. On 9/14/2020 at 1:30 p.m., during an interview, the registered dietitian (RD) stated Resident 1 was at risk for losing weight or being hydrated and she recommend Ensure Plus and health shake to supplement the resident's diet and prevent further weight loss. The nutritional supplement amount consumed was important to reassess weekly if the intervention was effective or to change to other interventions.

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