STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056053	A. BUILDING _____ B. WING _____	07/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRY VILLA HACIENDA HEALTHCARE CENTER	1311 EAST DATE STREET SAN BERNARDINO, CA 92404

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 0552 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are fully informed and understand their health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to notify the family of a change in condition for one of three sampled residents (Resident 1), when Resident 1 developed a pressure injury to the coccyx (tailbone) while in the facility, and they were not made aware during Resident 1's stay or upon discharge home to them. This failure had the potential to jeopardize the health of Resident 1, by not preparing the family with training on care of the pressure injury when Resident 1 was discharged home to their care. Findings: An unannounced visit was made to the facility on [DATE], to investigate a complaint of the family not being notified of a pressure injury Resident 1 acquired while at the skilled nursing facility. During a review of Resident 1's Face Sheet (demographics), the face sheet indicated Resident 1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident 1 was sent to the facility for rehabilitation for a fractured (broken) hip. The face sheet indicated Resident 1 was her own responsible party. and her daughter-in-law was listed as primary contact. During a review of the Resident Admission Assessment for Resident 1, dated November 11, 2018, the assessment of Resident 1's skin did not indicate Resident 1 had a pressure injury at the time of admission. A review of the Minimum Data Set (MDS- an electronic assessment tool) dated November 18, 2018, indicated under section M (Skin Conditions) a 1 which indicated the resident was at risk of developing pressure injuries. Section M indicted that Resident 1 was on a turning and repositioning program and had a surgical wound only During a review of the facility's Skilled Nursing Notes, for Resident 1, indicated in the section titled, Skin Condition-Additional Information for the following dates: a. November 13, 2018, indicated coccyx (tailbone), and no additional information as to why the coccyx had been listed was noted. b. November 15, 2018, did not show documentation for the coccyx, only the surgical wound from the [MEDICAL CONDITION] was listed c. November 17, 2018, indicated, coccyx and no additional information as to why the coccyx had been listed was noted. d. November 20, 2018, the section on skin condition was left blank. e. November 22, 2018, indicated coccyx and no additional information as to why the coccyx had been listed was noted. f. November 24,2018, indicated that pressure injury present was checked as yes, then listed coccyx with no additional information noted. g. November 29, 2018, indicated that pressure injury present was checked as yes, then listed coccyx with no additional information noted. h. November 30, 2018, indicated that a pressure injury was present and listed the coccyx and no additional information as to why the coccyx had been listed was noted. i. December 1, 2018, indicated, coccyx and no additional information as to why the coccyx had been listed was noted During a review of Resident 1's Physician Orders dated November 19, 2018, a telephone order was obtained for wound treatment for [REDACTED]. The order did not indicate the stage of the wound (wounds are staged I-IV based on how deep they penetrate). During a review of the facility's Interdisciplinary Team Conference Review, dated November 19,2018, Resident 1's son attended the conference. The documentation did not include any information or notification of the pressure injury to the son, that Resident 1 acquired while at the facility. During an interview and record review with the the Treatment Nurse (TX 1), and Director of Staffing Development (DSD) on January 8, 2019, at 12:38 PM, they could not locate documentation the family was made aware of the change in condition regarding Resident 1 acquiring a pressure injury. During a review of the facility policy and procedure titled, Change of Condition Notification, revised dated April 1,2015, indicates, Purpose-To Ensure residents, family, legal representatives and physicians are informed in a timely manner. Section .Family Notification, A. The Licensed Nurse will notify the family/surrogate decision -maker of any changes in the residents's condition as soon as possible. During a review of the facility policy and procedure titled, Pressure Injury and Skin Integrity Treatment revised dated August 12, 2016. .Purpose . To provide guidelines for the treatment of [REDACTED]. Section F. Document all notification of the family, resident and/or responsible party when there has been in the resident's skin condition.
F 0624 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Prepare residents for a safe transfer or discharge from the nursing home.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure preparation was provided for a safe transfer from the facility to the family home for one of three sampled residents (Resident 1), when the physician's orders [REDACTED]. wound or pressure injury. This failure had the potential for Resident 1 to not have the care and assistance needed at home which placed her at risk for falls and wound infections which could result in hospitalization . Findings: During a review of Resident 1's Face Sheet (demographics), the face sheet indicated Resident 1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident 1 was admitted to the facility for rehabilitation for a left [MEDICAL CONDITION]. During a review of the Resident Admission Assessment for Resident 1, dated November 11, 2018, the skin assessment section did not indicate Resident 1 had a pressure injury at the time of admission. During a review of the physician's orders [REDACTED]. A review of Notes written by the licensed nurse dated 11/29/18 indicated that the Social Service department had been made aware of the discharge orders. A review of the Notes dated December 1, 2018, the licensed nurse documented that the discharge was being appealed and the family will contact the Social Worker on Monday (December 3, 2018) During a review of the facility Notes dated December 3, 2018, indicated, D/C (discharged) home today at 12:50 PM; picked up by son and wife. D/C papers given to daughter in law, explained medication, and verbalized understand. Res(ident) in good spirits and eager to go home. D/C in stable condition, in W/C. During a review of the facility's Discharge Summary/Post Discharge Plan of Care, dated December 1, 2018, indicated that eight of ten sections which included the name of the home health agency, equipment needed or ordered for the resident, and special instructions to include wound care training and skin condition had been left blank. Under the section, Physician Visit, no follow up appointment had been made by the facility. The sections for Vital Signs; Cognition/Psychosocial status; Activity/Potential and Participation; Functional Status (activities of daily living)' and Skin Conditions, were blank. During an interview and record review on January 8, 2019, at 1:00 PM, with the Director of Nursing (DON), who reviewed the Discharge Summary/Post Discharge Plan of Care, Notes, and Physician's telephone orders; the DON confirmed the Discharge Summary was incomplete and should include; an appointment for follow up; the name of the home health agency, what type of equipment was ordered, and information regarding Resident 1's stage 2 Pressure Ulcer. The DON stated, no information was documented for the stage 2 pressure injury or the wound care that was to be provided. During a review of the facility's policy and procedure titled, Discharge and Transfer of Residents, revised date February, 2018, indicates .Purpose-To ensure that discharge planning is complete and appropriate and that necessary information is communicated to the continuing care provider. Procedure .7. Discharge Documentation Summary/Post Discharge Plan .C. The Discharge Summary/Post Discharge Plan will include documentation from the IDT (Interdisciplinary team -made up of various clinical department staff) regarding transfers or discharges and the following information as applicable .The identity of specific Community Agencies and services to be provided; equipment needs: specific equipment needed for the resident; special observations/ instructions to be reported to the physician; special

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

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COUNTRY VILLA HACIENDA HEALTHCARE CENTER	**1311 EAST DATE STREET SAN BERNARDINO, CA 92404**

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F 0624 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) training/instructions .
F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure for one of three sampled residents (Resident 1) to document the size and type of a pressure injury to the coccyx (tail bone) developed after admission to the facility, the effectiveness of the prescribed treatment, develop a written plan of care and notify the family of the wound upon discharge to the family home. This failure had the potential for inconsistent approaches from staff in providing wound care and further wound development, and for the family to not continue prescribed treatment and monitoring of the pressure injury to Resident 1's coccyx which could result in infection going undetected and unnecessary hospitalization . Findings: During a review of Resident 1's Face Sheet (demographics) the face sheet indicated Resident 1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident 1 was admitted to the facility for rehabilitation for a fractured (broken) left hip. During a review of Resident 1's physician's orders [REDACTED]. There was no documented [DIAGNOSES REDACTED]. November 13, 2018, indicated coccyx (tailbone), and no additional information as to why the coccyx had been listed was noted. b. November 15, 2018, did not show documentation for the coccyx, only the surgical wound from the [MEDICAL CONDITION] was listed c. November 17, 2018, indicated, coccyx and no additional information as to why the coccyx had been listed was noted. d. November 20, 2018, the section on skin condition was left blank. e. November 22, 2018, indicated coccyx and no additional information as to why the coccyx had been listed was noted. f. November 24,2018, indicated that pressure injury present was checked as yes, then listed coccyx with no additional information noted. g. November 29, 2018, indicated that pressure injury present was checked as yes, then listed coccyx with no additional information noted. h. November 30, 2018, indicated that a pressure injury was present and listed the coccyx and no additional information as to why the coccyx had been listed was noted. i. December 1, 2018, indicated, coccyx and no additional information as to why the coccyx had been listed was noted During a review of the facility Notes dated November 11, 2018, through December 3, 2018, there was no documented evidence of the size or stage of the pressure injury to the coccyx, no plan of care developed and no documented evidence the family was made aware of the wound and provided training on post discharge wound care. A review of the Treatment Administration Record dated November 1-30, 2018, reflected that there were two treatment orders being implemented for Resident 1. One order was for the surgical site on the left hip and showed it was resolved on November 26, 2018. The second indicated Coccyx (pressure injury), there was no stage listed, no initial or weekly measurements, just the initials of the licensed nurse signing to confirm the treatment ordered by the physician had been done daily as ordered from November 19-November 30, 2018. During an interview and record review of Resident 1's clinical record. with the treatment nurse on January 8, 2019 at 12:38 PM , she was unable to provide any documented evidence of the stage or size of the pressure injury on Resident 1's coccyx. She acknowledged there had been no notification of the family that a pressure injury had developed after admission to the facility. During an interview with the DON on January 8, 2019, at 1:00 PM, the DON reviewed the medical record and could not find a Care Plan (documents identifying nursing [DIAGNOSES REDACTED]. A review of the facility's policy and procedure titled, Pressure Injury and Skin Integrity Treatment, revised date August 12, 2016, was conducted with the Director of Nursing on January 8, 2019 at 1 PM. The policy indicated: Purpose.-To provide guidelines for the treatment of [REDACTED]. Guidelines .g, Preventive measures may be documented on the Treatment Administration record, the ADL (Activities of daily living) flow sheet, the Licensed Nurses Progress notes or the Licensed Nurses Weekly Summary. D. The Licensed Nurse will document the status of all skin conditions at least weekly or as otherwise indicated in the resident's Care Plan . F. Document all notifications of the family/resident and/or responsible party when there has been a change in the resident's skin condition. The Director of Nurses stated there had been no documentation of the pressure injury to the coccyx, no documented care plan, no documentation the family had been notified of the pressure ulcer, and no instructions had been provided to them regarding post-discharge wound care as per the facility's policy.