STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055060	A. BUILDING _____ B. WING _____	**08/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRY VILLA WESTWOOD	**12121 SANTA MONICA BOULEVARD LOS ANGELES, CA 90025**

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 0604 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to afford one of two sampled residents (Resident 1) the right to be free from physical restraints (any device attached or adjacent to the body that cannot be easily removed and restricts freedom of movement). Licensed Vocational Nurse 1 (LVN 1) tied Resident 1 to her wheelchair with an oxygen tank holder for wheelchairs. As a result, Resident 1's freedom of movement was inhibited and caused Resident 1 to call out for help and to feel scared. This deficient practice violated Resident 1's right causing a loss of dignity. Findings: A review of the Admission Record indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. of removing waste and excess water from the body). A review of Resident 1's Quarterly Minimum Data Set (MDS - a standardized assessment and screening tool) dated 6/5/2020 indicated Resident 1 had memory problems, was unable to make decisions, required total assistance with one-person physical assistance with all activities of daily living (ADLs - such as bed mobility, transfer, toilet use, and personal hygiene). A review of Resident 1's Change of Condition (COC) form, dated 6/18/2020, indicated staff reported Resident 1 was in a wheelchair with an oxygen strap around her. During an interview on 6/19/2020 at 1:15 p.m., Physical Therapist Assistant 1 (PTA 1) stated that on 6/18/2020 at around 1 p.m. or 2 p.m., she found Resident 1 in the room sitting in the wheelchair asking for help to go to the bathroom. PTA 1 stated she and Occupational Therapist Assistant 1 (OTA 1) moved Resident 1 into bathroom and observed Resident 1 tied to the wheelchair with a black oxygen tank holder/bag. Resident 1 was unable to get out of wheelchair. PTA 1 stated she with OTA 1 untied Resident 1 and assisted her onto the commode and then to the bed. PTA 1 and OTA 1 notified the Charge Nurse. On 6/19/2020 at 2:20 p.m., during an observation and concurrent interview, Resident 1 stated a woman had tied her onto her wheelchair; she was scared and could not get out of the wheelchair. Resident 1 stated she was calling for help to go to the bathroom and staff came and helped her. A review of the Corrective Action Memo, dated 6/25/2020, indicated Licensed Vocational Nurse 1 (LVN 1) was in charge, when Resident 1 was found restrained against her will and it was apparent LVN 1 failed to provide Resident 1 safety and was the primary suspect for placing the restraint on Resident 1. The facility terminated LVN 1. On 7/2/2020 at 9:35 a.m., during an interview, OTA 1 stated on 6/18/2020 she observed Resident 1 sitting in the wheelchair asking for help to go to the restroom. OTA 1 stated she took Resident 1 to the restroom and asked her to stand up but Resident 1 kept saying, Take it off. OTA 1 stated she removed the blanket off Resident 1 and noticed the resident tied to the wheelchair with an oxygen tank bag. OTA 1 stated she and PTA 1 removed the physical restraint. On 7/2/2020 at 10:35 a.m., a review of Resident 1's clinical record with the Director of Nursing (DON), indicated there was no documented physician's orders [REDACTED]. During an interview on 7/6/2020 at 8:43 AM the DON stated Resident 1 was found physically restrained to her wheelchair on 6/18/2020 by OTA and PTA. The DON stated the use of physical restraint was a last resort requiring physician order, IDT meeting for risk and benefits, and consent. She stated this process for the use of physical restraint was not conducted for Resident 1 physical restraint to wheelchair. She stated Resident 1's physical restraint is a form of physical abuse. She stated the potential outcomes of this type of physical restraint are bruising, fracture, hematoma, and potentially death. During an interview, on 7/6/2020 at 8:50 a.m., the Administrator stated the it was the facility's policy to get a physician's orders [REDACTED]. During an interview, on 7/6/2020 at 8:59 AM with Admin stated through the investigation he determined the most likely staff with access to Resident 1 to place her in physical restraint was Licensed Vocational Nurse 1 (LVN 1). The Admin stated LVN 1 was let go from the facility and he reported her to the nursing board. A review of the facility's policies and procedures titled, Restraints, revised 1/2012 indicated restraints require a physician's orders [REDACTED].

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