STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056425	A. BUILDING _____ B. WING _____	08/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VILLA ELENA HEALTHCARE CENTER	13226 STUDEBAKER RD NORWALK, CA 90650

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility's nursing staff failed to notify the physician and responsible party (RP) when one sampled resident (Resident A) sustained an assisted fall and later complained of pain and was noted with swelling to the left knee. This deficient practice resulted in Resident A's physician and RP not being made aware of Resident A's change of condition (COC) causing a delay in evaluation and treatment. Findings: A review of Resident A's Admission Records indicated Resident A was admitted to the facility on [DATE]. Resident A's [DIAGNOSES REDACTED]. A review of Resident A's Minimum Data Set (MDS), a resident assessment and care-screening tool, dated 12/9/19, indicated Resident A's cognitive (thought process) skills for daily decision-making were severely impaired. On 6/30/2020 at 9:15 a.m., during a telephone interview, Resident A's family member (FM 1) stated on 1/27/2020, FM 1 was eating lunch with Resident A when the resident complained of pain. FM 1 stated she told Licensed Vocational Nurse 1 (LVN 1) that Resident A was complaining of pain and LVN 1 stated the resident was already given pain medication. FM 1 stated Resident A was not doing any better so she reported Resident A's continued pain again to LVN 1, who was at the nursing station with the Director of Nursing (DON) and someone from the facility's corporate office. FM 1 stated the DON went to Resident A's room, touched her leg and Resident A yelled pain pain. FM 1 stated later an x-ray confirmed Resident A had a femur (large bone above the knee) fracture (broken bone). On 8/5/2020 at 11:47 a.m., Certified Nursing Assistant 1 (CNA 1) was contacted, via a phone call, but could not be interviewed because of a language barrier. A review of CNA 1's written statement indicated at 10 a.m., (1/27/2020) she reported to the charge nurse (LVN 1) that Resident A had pain and swelling in her knee. A review of Resident A's Department Notes, dated 1/28/2020 and timed at 12:36 p.m., a late entry for 1/27/2020, at 10 a.m., indicated at 10 a.m., a CNA (CNA 1) reported Resident A's left leg was swollen. On assessment Resident A was noted with swelling to her left leg, pain medication was given and CNA was instructed to report any changes. A review of a written statement by LVN 1, dated 1/28/2020, indicated a CNA (CNA 1) reported to her that Resident A's left knee was swollen. LVN 1's documentation indicated she (LVN 1) assessed Resident A and noted discomfort and a difference in Resident A's knees. LVN 1 documented she gave Resident A pain medication (Tylenol) and asked CNA 1 to notify her of any changes. A review of Resident A's clinical records indicated no written evidence that the physician or Resident A's RP were notified of Resident A's left leg pain or swelling. On 8/5/2020 at 11:08, during a telephone interview, LVN 1 stated CNA 1 reported to her that Resident A complained of pain to her knee. LVN 1 stated Resident A was already in her wheelchair when she went to assess her. LVN 1 stated when she touched Resident A's knee she noticed her facial expression changed indicating she was in discomfort. LVN 1 stated normally the Case Manager or registered nurse (RN) supervisor calls the physician to report changes with the residents, so no she did not call the physician. LVN 1 stated she can't remember if she reported Resident A's pain to the registered nurse supervisor (RN 1) but stated she did not call Resident A's RP. A review of the facility's undated policy and procedure (P/P) titled, Change in a Resident's Condition or Status, indicated our facility shall promptly notify the resident, his or her attending physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care). The nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician when there has been: a discovery of injuries of an unknown source. Unless otherwise instructed by the resident, the nurse supervisor/charge nurse will notify the resident's family or representative (sponsor) when: the resident is involved in any accident or incident that results in an injury including injuries of an unknown source.
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's nursing staff failed to notify the physician in a timely manner when one sampled resident (Resident A) complained of pain to her knee and her leg was noted with swelling. This deficient practice resulted in Resident A's physician not being notified of Resident A's painful swollen leg for three hours after it was discovered and a delay in evaluation and treatment. Findings: A review of Resident A's Admission Records indicated Resident A was admitted to the facility on [DATE]. Resident A's [DIAGNOSES REDACTED]. A review of Resident A's Minimum Data Set (MDS), a resident assessment and care-screening tool, dated 12/19/19, indicated Resident A's cognitive (thought process) skills for daily decision-making were severely impaired. A review of Resident A's Department Notes, dated 1/28/2020 at 12:36 p.m., noted as a late entry for 1/27/2020, at 10 a.m., indicated at 10 a.m., a certified nursing assistant ((CNA) CNA 1) reported Resident A's left leg was swollen. On assessment Resident A was noted with swelling to her left leg, pain medication was given and the CNA was instructed to report any changes. A review of Resident A's Department Note, dated 1/27/2020 at 1:06 p.m., (three hours after pain and swelling were noted to Resident A's leg) indicated Resident A's responsible party (RP) reported Resident A was complaining of pain to her left thigh. The note indicated upon assessment no discoloration was noted. Palpated (to feel) the area from the upper knee to the mid-thigh on the left leg and Resident A had facial grimacing and a verbal complaint of pain. Noted with mild swelling as compared to the right leg. The physician was made aware and an order for [REDACTED]. distal left femur (just above the knee joint). On 8/5/2020 at 10:15 a.m., during a telephone interview, Registered Nurse Supervisor (RN 1) stated she was at the nurses station when Resident A's RP reported to her that Resident A was complaining of pain. RN 1 stated she went to Resident A's room and assessed her and noted slight swelling to Resident A's left leg near her knee. RN 1 stated when she touched Resident A's leg and noted the resident had facial grimacing and verbally complained of pain. RN 1 stated later she discovered Resident A had complained of pain and swelling was noted to her leg earlier that morning (10 a.m.) but no one reported that to her. RN 1 stated nurses are instructed to report any change of condition to her so that she can take appropriate steps to notify the physician. On 8/5/2020, at 11:08, during a telephone interview, Licensed Vocational Nurse 1 (LVN 1) stated CNA 1 reported to her that Resident A complained of pain to her knee. LVN 1 stated Resident A was already in her wheelchair when she went to assess her. LVN 1 stated she touched Resident A's knee and noticed her facial expression changed indicating she was in discomfort. LVN 1 stated she could not remember if she reported Resident A's pain to RN 1. A review of the facility's undated policy and procedure (P/P) titled, Change in a Resident's Condition or Status, indicated our facility shall promptly notify the resident, his or her attending physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care). The nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician when there has been: a discovery of injuries of an unknown source.

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.

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Unless otherwise instructed by the resident, the nurse supervisor/charge nurse will notify the resident's family or representative (sponsor) when: the resident is involved in any accident or incident that results in an injury including injuries of an unknown source.
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility's nursing staff failed to document in the clinical record for one sampled resident (Resident A) when Resident A had an assisted fall to the floor and when she later complained of pain to her knee. This deficient practice resulted in no documented evidence of Resident A's change of condition (COC) and had the potential to affect the resident's continuity of care. Findings: A review of Resident A's Admission Records indicated Resident A was admitted to the facility on [DATE]. Resident A's [DIAGNOSES REDACTED]. A review of Resident A's Minimum Data Set (MDS), a resident assessment and care-screening tool, dated 12/19/19, indicated Resident A's cognitive (thought process) skills for daily decision-making were severely impaired. A review of Resident A's Department Notes, dated 1/30/2020 at 10:35 a.m., (three and half days after the assisted fall incident) noted as a late entry for 1/26/2020, at 11:30 p.m., indicated while doing rounds Resident A was observed attempting to get out of bed. At 1:15 a.m., (1/27/2020), Licensed Vocational Nurse 2 (LVN 2) observed Resident A trying to get out of bed. LVN 3 ran to the room and noted Resident A sitting on the edge of the bed with her feet dangling to the floor and sliding down from the bed. Resident A was caught under her arms and with help from LVN 2 was slowly to the floor. A review of Resident A's Department Notes, dated 1/28/2020 at 12:36 p.m., noted as a late entry for 1/27/2020, at 10 a.m., indicated at 10 a.m., a certified nursing assistant ((CNA) CNA 1) reported Resident A's left leg was swollen. On assessment Resident A was noted with swelling to her left leg, pain medication was given and CNA was instructed to report any changes. On 8/5/2020 at 11:08 a.m., during a telephone interview, LVN 1 stated CNA 1 reported to her that Resident A complained of pain to her knee. LVN 1 stated Resident A was already in her wheelchair when she went to assess her. LVN 1 stated when she touched Resident A's knee and noticed her facial expression changed indicating the resident was in discomfort. LVN 1 stated she should have documented in Resident A's clinical records the pain that was reported, her assessment and treatment of [REDACTED]. mental condition, shall be documented in the resident's medical record. All observation, medications administered, services performed, etc., must be documented in the resident's clinical records. All incidents, accidents, or changes in the resident's condition must be recorded.