STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055160	A. BUILDING _____ B. WING _____	03/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRY VILLA PAVILION NURSING CENTER	5916 W. PICO BOULEVARD LOS ANGELES, CA 90035

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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 9) investigated for accommodation of needs had a functioning call light. This deficient practice had the potential to affect the resident's ability to call for assistance when needed. Findings: A review of Resident 9's Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with a contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of the right and left shoulders and knees, and unspecified dementia (an overall term for diseases and conditions characterized by a decline in memory, language, problem-solving and other thinking skills that affect a person's ability to perform everyday activities) without behavioral disturbance. A review of Resident 9's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 11/18/19, indicated the resident was severely impaired in cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) and was totally dependent on staff for bed mobility, transfers, locomotion on and off the unit, dressing, eating, toilet use, and personal hygiene. On 3/7/20 at 9:20 a.m., during an observation, Resident 9 was asleep in bed. The resident's call light was observed to not be within reach. The call light was hanging on the wall behind the resident and not connected. On 3/7/20 at 9:39 a.m., during a concurrent observation and interview, Licensed Vocational Nurse 2 (LVN 2) verified that the resident's call light was not within the resident's reach and, upon closer observation, noted that the cord was cut. LVN 2 stated she would immediately notify maintenance about it. A review of Resident 9's care plan for communication deficit, initiated on 8/10/19, indicated to keep the resident's call light within reach. A review of Resident 9's care plan for fall risk prevention and management, initiated on 8/9/19, indicated to keep the resident's call light within reach. On 3/8/20 at 6:21 p.m., during an interview, the Director of Nursing (DON) stated it was important for residents to have a functioning call light so the resident is able to ask for help, especially for an emergency. A review of the facility's policy and procedure titled, Communication - Call System, revised on 1/1/12, indicated that the facility will provide a call system to enable residents to alert the nursing staff from their rooms and toileting/bathing facilities. Call cords will be placed within the resident's reach in the resident's room. If call bell is defective, it will be reported immediately to maintenance and replaced immediately.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement its abuse prevention, investigation, and reporting policies and procedures for two of two residents investigated under care area of abuse by: 1. Failing to complete a thorough investigation addressing a resident to resident allegation of abuse involving Residents 1. 2. Failing to complete a thorough investigation addressing a staff to resident allegation of abuse involving Resident 23. This deficient practice had the potential to result in unidentified abuse in the facility and failure to protect residents from abuse. Findings: A. A review of Resident 1's Face Sheet (admission record) indicated the resident was initially admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 1's History and Physical (H&P), dated 3/6/20, indicated the resident had the capacity to understand and make decisions. A review of Resident 1's Minimum Data Set (MDS - a residents' assessment and screening tool) dated 1/25/20, indicated the resident had severe impairment in cognition (mental action or process of acquiring knowledge and understanding) skills for daily decision-making. The MDS indicated the resident required limited physical assistance for transfer, dressing, toileting, personal hygiene, required supervision for bed mobility and is independent with eating. A review of the facility-provided SOC 341 (form used for reporting suspected dependent adult/elder abuse) dated 2/28/20 indicated the report was related to physical abuse of Resident 1, with no physical injury. The form indicated Resident 1 claimed she was hit by another resident on the right side of her face. No injuries were observed and both residents were separated immediately. During an interview and concurrent record review of the abuse investigation on 3/8/20 at 7:00 p.m., the investigation did not mention any interventions in place to prevent further abuse. The Director of Nursing (DON) agreed that the conducted abuse investigation was not a thorough and detailed investigation. The DON stated that they should have mentioned what they have put in place to prevent any further abuse. B. A review of Resident 23's Face Sheet indicated the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. reality, disorganized speech or behavior, and decreased participation in daily activities), and [MEDICAL CONDITION] disorder (mental disorder marked by extreme mood swings of ecstatic and energized behavior to very sad or hopeless periods). A review of Resident 23's Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 1/15/20, indicated the resident had moderately impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated the resident required limited to extensive assistance with most activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). A review of the facility-provided SOC 341 (form used for reporting suspected dependent adult/elder abuse) dated 2/28/20, indicated the report was related to physical abuse of Resident 23 with no physical injury by Certified Nursing Assistant 3 (CNA 3). The form indicated Resident 23 stated that a nurse hit her after midnight on 2/28/20 around 1:00 am - 1:30 a.m. The form also indicated Resident 23 stated the nurse attended to her six times a week. The form indicated police came to investigate the incident. On 3/8/20 at 9:40 a.m., during an interview, Resident 23 stated a nurse slapped her on the head. Resident 23 was unable to recall the name of the nurse and was unable to fully elaborate the incident. A review of the facility's final conclusion letter, dated 3/4/20, did not indicate what interventions were placed to ensure further potential abuse will be prevented. During an interview, on 3/8/20 at 7:00 p.m., the Director of Nursing (DON) agreed that the investigation conducted by the facility was not a thorough and detailed investigation. The DON stated that they should have indicated the interventions they have put in place to prevent further recurrence of the physical altercation. A review of the facility's policy and procedures titled, Abuse - Reporting & Investigations, dated 03/2018, indicated the purpose is to protect the health, safety, and welfare of facility residents by ensuring that all reports of resident abuse are promptly reported and thoroughly investigated. The Administrator will provide a written report of the results of all abuse investigations and appropriate action taken to California Department of Public Health (CDPH) Licensing and Certification and others that may be required by state or local laws, within five working days of the reported allegation.
F 0638 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Assure that each resident's assessment is updated at least once every 3 months.** Based on interview and record review, the facility failed to ensure the Quarterly Minimum Data Sets (MDS - a comprehensive standardized assessment and screening tool) were completed within the required time frame for one of two sampled residents (Resident 2) investigated under facility task of Resident Assessments. This deficient practice had the potential to negatively affect the provision of necessary care and services for Resident 2. Findings: A review of Resident 2's

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 0638 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	(continued... from page 1) Quarterly Minimum Data Set (MDS - a standardized assessment and screening tool), with assessment reference date (ARD - observation end date) of 11/1/19, indicated the resident's most recent admission to the facility was on 6/2/19. The MDS was signed as complete on 12/18/19. A review of the facility-provided Centers for Medicare and Medicaid Services (CMS) Submission Report/Final Validation Report, dated 12/19/19, indicated Resident 2's MDS was completed late. The completion date (12/18/19) was more than 14 days after 11/1/19 (ARD). A review of Resident 2's Quarterly MDS with ARD of 1/29/20, indicated the resident's most recent admission to the facility was on 6/2/19. The MDS was signed as complete on 3/7/20. A review of the facility-provided CMS Submission Report/Final Validation Report, dated 3/8/20, indicated Resident 2's MDS was completed late. The completion date (3/7/20) was more than 14 days after 1/29/20 (ARD). During an interview and concurrent record review, on 3/8/20 at 2:49 p.m., Minimum Data Set Coordinator (MDS) stated both of Resident 2's Quarterly MDS assessments were completed late; they should have been completed on 11/15/19 and 2/12/20 respectively. MDS stated it is important to timely complete the MDS assessments for care planning purposes. A review of the facility's policy and procedures titled Resident Assessment Instrument (RAI) Process, revised on 10/4/16, indicated the purpose was to provide resident assessments that accurately depict and identify resident-specific issues and objectives as required, while meeting state and federal guidelines and data submission requirements. A review of the facility-provided CMS Resident Assessment Instrument (RAI) User's Manual Version 3.0 dated 10/2019, indicated for all non-Admission assessments, the MDS completion date must be no later than 14 days after the assessment reference date (ARD).
F 0640 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS - a standardized assessment and screening tool) was submitted (transmitted) timely to the Centers for Medicare and Medicaid Services (CMS) system for two of two residents investigated under facility task of Resident Assessments (Resident 1 and 2). This deficient practice had the potential to delay care and services for Resident 1 and 2. Findings: A. A review of Resident 1's Admission Record indicated the resident was initially admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 1's History and Physical (H&P), dated 3/6/20, indicated the resident had the capacity to understand and make decisions. A review of Resident 1's MDS dated [DATE], indicated the resident had severe impairment in cognition (mental action or process of acquiring knowledge and understanding) skills for daily decision-making. The MDS indicated the resident required limited physical assistance for transfer, dressing, toileting, personal hygiene, required supervision for bed mobility and is independent with eating. During an interview on 3/8/20 at 1:41 p.m. with Minimum Data Set Nurse (MDS), MDS Nurse confirmed that Resident 1's MDS was a late submission. MDS Nurse stated that it should be transmitted within 14 days of the completion date of the resident's assessment. B. A review of Resident 2's Quarterly Minimum Data Set (MDS - a standardized assessment and screening tool) dated 8/5/19 indicated the resident's most recent admission to the facility was on 6/2/19. The MDS was signed as complete on 8/19/19. A review of the facility-provided Centers for Medicare and Medicaid Services (CMS) Submission Report/Final Validation Report, dated 9/4/19, indicated Resident 2's MDS was submitted (transmitted) late. The submission date was more than 14 days after 8/19/19 (completion date). During an interview and concurrent record review, on 3/8/20 at 2:49 p.m., Minimum Data Set Coordinator (MDS) stated Resident 2's Quarterly MDS was submitted late. MDS stated the record should have been submitted on 9/2/19. A review of the facility's policy and procedures titled Resident Assessment Instrument (RAI) Process, revised on 10/4/16, indicated the purpose was to provide resident assessments that accurately depict and identify resident-specific issues and objectives as required, while meeting state and federal guidelines and data submission requirements. A review of the facility-provided CMS Resident Assessment Instrument (RAI) User's Manual Version 3.0 dated 10/2019, indicated Quarterly MDS assessments must be submitted within 14 days of the MDS completion date. A review of the facility-provided CMS Resident Assessment Instrument (RAI) Version 3.0 Manual dated 10/2019, indicated the comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date. All other assessments must be submitted within 14 days of the MDS Completion Date.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident's fall care plan was revised after one of one resident (Resident 41) had an episode of actual fall. This deficient practice had the potential to affect the provision of necessary care and services for Resident 41. Findings: A review of Resident 41's Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. to perform everyday activities) without behavioral disturbance. A review of Resident 41's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 1/23/20, indicated the resident was severely impaired in cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making and was totally dependent on staff for transfers, locomotion on and off the unit, dressing, eating, toilet use, and personal hygiene. On 3/8/20 at 10:25 a.m., during a concurrent interview and record review, Licensed Vocational Nurse 2 (LVN 2) stated that the resident's fall care plan was not updated after the resident's recent fall to reflect the new interventions that were implemented. LVN 2 stated it was important to update the resident's care plan after a fall in order to prevent another fall from occurring. On 3/8/20 at 6:17 p.m., during an interview with the Director of Nursing (DON), DON stated that it was important to update the fall care plan after a fall because it is a way to communicate with all staff responsible for the resident's care regarding the proper interventions to help prevent the reoccurrence of a fall. A review of the facility's undated policy and procedure titled, Fall Management Program, indicated that the purpose of the policy was to provide a safe environment that minimizes complications associated with falls. Following each resident fall, the Licensed Nurse will perform a Post-Fall Assessment and update, initiate or revise a Plan of Care.
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 observation, interview, and record review, the facility failed to set the residents' low air loss mattresses (LALM - a pressure-relieving mattress used to prevent and treat pressure injuries (localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device)) according to their weights for two of six residents (Residents 3 and 46) investigated under the care area of pressure ulcer/injury. This deficient practice placed the residents at risk for discomfort and development of pressure injuries. Findings: A. A review of Resident 3's Face Sheet (admission record) indicated the resident was admitted to the facility on [DATE] and was readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 3's Minimum Data Set (MDS - a standardized assessment and screening tool) dated 2/15/20, indicated the resident had severely impaired cognitive skills (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect everyday life) for daily decision-making. The MDS indicated the resident was totally dependent with activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS also indicated the resident was at risk of developing pressure ulcers/injuries. One of the treatments indicated the use of pressure reducing device for the bed. A review of Resident 3's Care Plan dated 10/22/19 addressing risk for skin break/ulcer formation indicated the resident's risk factors for skin breakdown included impaired mobility (state of not being able to independently move around), incontinence (lack of voluntary control over urination or defecation), cognitive impairment, and history of pressure ulcers. The Care Plan indicated a goal of minimizing the risk for skin breakdown. One of the approaches (interventions) indicated to provide pressure redistributing devices (low air loss mattresses (LALM) - used to prevent and treat pressure injuries) and assess for effectiveness. During an observation on 3/7/20 at 12:06 p.m., Resident 3 was observed in bed with the LALM setting dial pointed between 250 - 280 pounds (lbs. - unit of measurement of weight). On 3/7/20 at 6:08 p.m., during an interview and a concurrent review of Resident 3's health records, Registered Nurse 1 (RN 1) stated Resident 3's LALM setting should

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement the physician's order to provide bilateral floor mats for one of four sampled residents (Resident 7). This deficient practice had the potential to result in serious injury such as like fractures (break in the bone) and bleeding that may accompany falls. Findings: A review of Resident 7's Face Sheet (admission record) indicated the resident was admitted to the facility on [DATE] and was readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 7's Minimum Data Set (MDS - a standardized assessment and screening tool) dated [DATE], indicated the resident had severely impaired cognition (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect everyday life). The MDS also indicated the resident was totally dependent with activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). A review of Resident 7's Physician Orders indicated an order dated 4/3/19 to provide bilateral floor mats due to fall from bed. A review of Resident 7's Care Plan addressing risk for fall, updated on 2/28/19, indicated the goal was to provide safe environment that minimizes complications associated with falls. One of the approaches (interventions) indicated to provide mat at bedside. A review of Resident 7's Medication Administration Record [REDACTED]. On 3/8/20 at 9:10 a.m., during an observation and a concurrent interview, observed Resident 7 in bed. There were no bilateral floor mats observed. Registered Nurse 1 (RN 1) confirmed and agreed that having the bilateral floor mats in place is important to lessen the risk of injury should the resident rolls off from the bed. A review of the facility's policies and procedures titled Fall Management Program, revised on 11/7/16, indicated the purpose was to provide a safe environment that minimizes complications associated with falls. The plan of care will be reviewed and the care plan will be revised as necessary in an effort to prevent further falls with major injury.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to adequately identify the specific targeted behavior on the use of [MEDICATION NAME] (an antipsychotic medication used to manage [MEDICAL CONDITION] (abnormal condition of the mind described as involving a loss of contact with reality)) for one of five residents (Resident 45) reviewed for unnecessary medications. This deficient practice had the potential to place the resident at risk for unnecessary medication and adverse effects (any unexpected or dangerous reaction to a drug) such as daytime drowsiness, confusion, dizziness, and increased risk of falls. Findings: A review of Resident 45's Face Sheet (admission record) indicated the resident was admitted to the facility on [DATE] and was readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 45's Minimum Data Set (MDS - a standardized assessment and screening tool) dated 1/23/20 indicated the resident had severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision-making. The MDS indicated the resident was totally dependent with activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS also indicated the resident received antipsychotic medication. A review of Resident 45's physician's orders [REDACTED]. During an interview with Registered Nurse 1 (RN 1) and a concurrent review of Resident 45's health records on 3/8/20 at 9:53 a.m., the resident's Monthly [MEDICAL CONDITION] Summary Sheet (monthly review of resident's behaviors and adverse reactions to the use of medications capable of affecting the mind, emotions, and behavior) indicated the facility has been evaluating the effectiveness of [MEDICATION NAME] from 8/1/19 to 1/31/20. The record did not indicate the specific behavior monitored to determine the effectiveness of [MEDICATION NAME]. The behaviors evaluated were the presence of hallucinations and severe agitation. RN 1 stated the resident had visual (seeing things that are not there) and auditory (perception of sound that is not there) hallucinations. RN 1 also stated the resident's restlessness was manifested by episodes of leaning forward and sitting back multiple times and inability to remain calm. During an interview, on 3/8/20 at 10:09 a.m., RN 1 stated it is important to monitor the specific behavior on the use of [MEDICATION NAME] to determine if the resident's current dose is correct or not; sometimes they have to update the psychiatrist if the medication is working depending on the specific behaviors manifested. A review of the facility's policy and procedures titled, Behavior/Psychoactive Drug Management, revised in 11/2018, indicated the purpose was to provide a therapeutic environment that supports residents to obtain or maintain the highest physical, mental, and psychosocial well-being. Any order for psychoactive ([MEDICAL CONDITION] - any drug used to control behavior or treat a disordered thought process) medications must include the specific behavior manifested.
F 0813 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have a policy regarding use and storage of foods brought to residents by family and other visitors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to monitor the residents' foods brought into the facility and stored inside one of one facility refrigerator designated for residents' foods. This deficient practice had the potential to result in food contamination and food-borne illnesses (infection or irritation of the gastrointestinal tract caused by food or beverages that contain bacteria, parasites, viruses, or chemicals; symptoms include vomiting, diarrhea, abdominal pain, fever, and chills) to all residents and can lead to serious medical complications [REDACTED]. A sign on the door indicated all items stored in refrigerator must be labeled with name, room number, dated (date of storage

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F 0813 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) in the refrigerator) and must be discarded after 48 hours of storage. Items without name and date will be discarded. The following items were observed and confirmed with LVN 1: 1. One container of Ensure (brand of nutritional supplement) labeled with a room number. It did not indicate the name of the resident or the date it was stored inside the refrigerator. 2. One yogurt labeled with a room number and initials. It did not indicate the name of the resident or the date it was stored inside the refrigerator. The yogurt had a best by date (indicates when a product will be of best flavor or quality) of 03/2020. 3. One container of frozen sport drink labeled with a resident's last name. It did not indicate the resident's first name or the date it was stored inside the refrigerator. The container did not indicate an expiration date. 4. One container of frozen Ensure with no name of resident and no date when it was placed in the refrigerator. During a concurrent interview with LVN 1 on 3/8/20 at 3:08 p.m., LVN 1 stated that the container of frozen Ensure with no name and no date should be discarded. LVN 1 was observed disposing the container. On 3/08/20 at 7:42 p.m., during an interview, the Director of Nursing (DON) stated food from home has to be labeled with the name of resident and the date it was placed in the refrigerator; after 24 hours (hrs), if not consumed, the food should be thrown out. The DON stated sealed foods and drinks should have been labeled with the name of the resident and date received/placed in the refrigerator. A review of the facility's policies and procedures titled Food Brought in by Visitors, revised on 06/2018, indicated the purpose was to provide residents with the option of having food prepared or purchased by the residents' visitors brought into the facility. The nurse assigned to the resident will account for the resident's intake of food from sources outside the facility. The facility should ensure safe food handling once the food is brought to the facility. Perishable food requiring refrigeration will be discarded after two hours at bedside, and if refrigerated, it will then be labeled, dated, and discarded after 48 hours.
F 0814 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Dispose of garbage and refuse properly.** Based on observation, interview, and record review, the facility failed to ensure garbage and kitchen refuse (trash) were secured with the dumpsters' lids closed and were not overflowing for two of two facility dumpsters. This deficient practice had the potential to result in harboring, feeding, and attracting pests and vermin. Findings: During a kitchen observation and a concurrent interview on 3/8/20 at 7:56 p.m., two black garbage dumpsters were noted to be overflowing with trash; the lids were not fully closed and not covering all the trash. Dietary Supervisor (DS) stated facility trash is picked up six days a week except Sundays. DS agreed that garbage dumpsters' lids should be closed shut to avoid attracting pests. A review of the facility's policy and procedures titled Pest Control - Physical Environment, revised on 1/1/12, indicated the purpose was to ensure the facility is free of insects, rodents, and other pests that could compromise the health, safety, and comfort of residents, staff, and visitors. Garbage and trash are not permitted to accumulate in any part of the facility. Garbage and trash are removed from the facility as needed, and at least once daily.
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 failed to maintain complete and accurate medical records in accordance with accepted professional standards for one of one resident (Resident 41) by failing to completely document the Neurological Check Form (used to assess an individuals nerve functions and level of consciousness in order determine whether or not individual is functioning properly and reacting appropriately to the tests being performing). These deficient practice had the potential to result in confusion in the care and services provided to the residents, which could place the residents at risk of not receiving appropriate care due to inaccurate and incomplete resident medical care information. Findings: A review of Resident 41's Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. to perform everyday activities) without behavioral disturbance. A review of Resident 41's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 1/23/20, indicated the resident was severely impaired in cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making and was totally dependent on staff for transfers, locomotion on and off the unit, dressing, eating, toilet use, and personal hygiene. On 3/8/20 at 10:25 a.m., during a concurrent interview and record review, Licensed Vocational Nurse 2 (LVN 2) stated Resident 41 had an unwitnessed fall in January. Upon review of the 72 Hour Neurological Check Form, it was noted that the form was incomplete. The 5:30 p.m. and 9:30 p.m. columns were left blank. LVN 2 stated that the columns should have been filled out, and if the resident was asleep during those hours, then the nurses should have documented that the resident was asleep. On 3/8/20 at 6:17 p.m., during an interview, the Director of Nursing (DON) stated that it was important to completely document a 72-hour neurological check after an unwitnessed fall in order to know if the resident was becoming more confused or remaining stable.
F 0911 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to meet the requirement for no more than four residents per room for two of 20 resident rooms (room [ROOM NUMBER] and 23). This deficient practice had the potential to result in inadequate space to provide sufficient nursing care and privacy for the residents. Findings: A review of the Client Accommodation Analysis form completed by the facility, indicated room [ROOM NUMBER] and 23 housed five beds per room. During the Resident Council Meeting on 3/7/20 at 1:30 p.m., when the residents were asked about their room space, there were no concerns or issues brought up. During the recertification survey from 3/7/20 to 3/8/20, room [ROOM NUMBER] and 23 were observed to house five beds per room. The residents residing in the rooms (with an application for variance,) had a sufficient amount of space for residents to move freely inside the rooms. There is adequate room for the operation and use of wheelchairs, walkers, or canes. The room variance did not affect the care and services provided by nursing staff for the residents. On 3/8/20, the Administrator submitted a letter requesting for a waiver for room with more than four residents per room for the following rooms: - room [ROOM NUMBER]- with five residents - room [ROOM NUMBER]- with five residents A review of the waiver letter dated 4/9/19, indicated, There is enough space to provide for each resident care, dignity, and privacy. The rooms are in accordance with the special needs of the resident and would not have an adverse effect on the resident's health and safety or impede the ability of any resident in the rooms to attain his or her highest practicable well-being.
F 0912 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.** Based on observation, interview and record review, the facility failed to ensure that 18 of 20 resident rooms (Rooms 4, 5, 6, 7, 8, 9, 10, 11, 14, 15, 16, 17, 18, 19, 20, 21, 22, and 24) met the square footage requirement of 80 square feet (sq. ft.) per resident in multiple resident rooms. The size for these rooms had the potential to have inadequate space for resident care and mobility. Findings: During the Resident Council Meeting on 3/7/20 at 1:30 p.m., the residents were asked about their room space, there were no concerns or issues brought up. During the recertification survey from 3/7/20 to 3/8/20, the residents residing in the rooms with an application for variance were observed with sufficient amount of space for residents to move freely inside the rooms. There was adequate room for the operation and use of wheelchairs, walkers, or canes. The room variance did not affect the care and services provided by nursing staff for the residents. On 3/8/20, the Administrator submitted the application for the Room Variance Waiver for 18 resident rooms. The room variance letter indicated that these rooms did not meet the 80 square feet per resident requirement per federal regulation. The room waiver request showed the following: Room # Square Footage (sq ft) Bed Capacity Sq Ft per Resident 4 154.9 2 77.45 5 154.9 2 77.45 6 154.9 2 77.45 7 154.9 2 77.45 8 154.9 2 77.45 9 154.9 2 77.45 10 220.9 3 73.63 11 220.9 3 73.63 14 220.9 3 73.63 15 220.9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055160	A. BUILDING _____ B. WING _____	**03/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRY VILLA PAVILION NURSING CENTER	**5916 W. PICO BOULEVARD LOS ANGELES, CA 90035**

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 0912 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	(continued... from page 4) 3 73.63 16 220.9 3 73.63 17 220.9 3 73.63 18 220.9 3 73.63 19 220.9 3 73.63 20 220.9 3 73.63 21 220.9 3 73.63 22 220.9 3 73.63 24 316.34 4 79.08 The minimum requirement for a 2 bedroom should be at least 160 sq. ft. The minimum requirement for a 3 bedroom should be at least 240 sq. ft. The minimum requirement for a 4 bedroom should be at least 320 sq. ft. A review of the room waiver letter dated 4/9/19, indicated, There is enough space to provide for each resident care, dignity, and privacy. The rooms are in accordance with the special needs of the resident and would not have an adverse effect on the resident's health and safety or impede the ability of any resident in the rooms to attain his or her highest practicable well-being.