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 _____	**08/19/2020**

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 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: 1. Follow its' policy and procedure related to change of condition documentation after a resident-to-resident altercation for one of three sampled residents (Resident 1), and 2. Implement the care plan intervention by monitoring one of three sampled residents (Resident 1) after a resident-to-resident altercation. These deficeint practices had the potential to result in a lack of continuity of care and treatment . Findings: On 2/27/2019, at 1:40 p.m., an unannounced visit was made to the facility to investigate a facility reported incident regarding a resident to resident incident. 1. A review of Resident 1's Admission Record indicated Resident 1 was readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS-an assessment and care planning tool) dated 2/5/2019, indicated Resident 1 has clear speech, ability to express ideas and wants and clear comprehension (understanding). The MDS further assessed Resident 1 as requiring limited assistance with transfer (how resident moves between surfaces including to and from: bed, chair, wheelchair, standing position), toilet use, and personal hygiene. A record review of Resident 1's clinical records indicated there was no documented the Situation-Background-Assessment-Recommendation (SBAR- a form that provides a framework for communication between members of the health care team about a patient's condition). The SBAR indicated a resident to resident altercation occurred on 2/9/2019. A record review of the Licensed Personnel Weekly Notes dated 2/9/2019 through 2/12/2019 was conducted. The Licensed Personnel Weekly Note indicated Resident 1 was being monitored for a fall. There was no documentation indicating monitoring Resident 1for a resident to resident altercation and monitoring for signs and symptoms of infection. During a interview and a concurrent record review of Resident 1's clinical records with the Director of Nursing (DON) on 2/27/30/2019 at 3:00 p.m., the DON reviewed Resident 1's clinical records. The DON stated Resident 1 does not have a written SBAR indicating a resident to resident altercation occurred. The DON further stated the SBAR would indicate: a physical assessment of Resident 1's condition, nursing documentation of what occurred, time and date physician and responsible party were notified and recommendations of the primary clinicians. During an interview with the DON, on 2/27/2019 at 3:30 p.m., the DON stated she documented the SBAR but was unable to provide a documented SBAR. The DON refused to state what may happen to a resident if there's no documented SBARor physicial assessment. 2. Resident 1's care plan titled Short Term dated 2/9/2019, indicated the problem is a resident to resident altercation. Resident 1 received a small laceration to the forehead. Nursing interventions included to monitor for emotional distress and signs and symptoms of infection, monitor/observe for any signs of aggression, and move Resident 1 to another room. A review of the facility policy titled Change of Condition Notification dated April 1,2015, indicated, A licensed nurse will document date, time and pertinent details of the incident and the subsequent assessment in the nursing notes. The time the attending physician was contacted, the method by which he was contacted, the response time, and whether or not orders were received. A licensed nurse will document each shift for at least seventy-two (72) hours. Documentation pertaining to a change in the resident's condition will be maintained in the resident's medical record and on the twenty-four hour report.

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.