STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555397	A. BUILDING _____ B. WING _____	**04/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRY VILLA REHABILITATION CENTER	**340 SOUTH ALVARADO STREET LOS ANGELES, CA 90057**

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 -** 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 ensure one of three sampled residents (Resident 1), who was diagnosed with [REDACTED]. (elevated blood sugar) status, and failed to follow facility policy on Blood Glucose Monitoring (amount of sugar in the blood). Resident 1 had an elevated blood glucose level of 410 mg/dl (normal 80 - 100) on [DATE], which was not reported to the physician. The resident was found unconscious, transferred to the General Acute Care Hospital (GACH), where she was diagnosed with [REDACTED]. Findings: On [DATE] an unannounced visit was made to the facility to investigate a complaint regarding quality of care and treatment. A review of the Admission Record indicated Resident 1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 1's Care Plan for [MEDICAL CONDITION] related to diabetes mellitus was initiated on [DATE]. The care plan goal indicated resident was to have no complications related to diabetes through the review date of [DATE]. The interventions indicated to give medication as ordered by doctor, monitor/document side effects and effectiveness and to monitor/document and report to the physician signs and symptoms of [MEDICAL CONDITION] (frequent urination, weight loss, dry skin, poor healing, stupor and coma). The Care Plan did not address notifying the physician when the blood sugar was above 401mg/dl, nor did it address checking the blood sugar prior to transportation. A review of the physician's orders [REDACTED]. According to a review of the Minimum Data Set (MDS - a standardized assessment and care screening tool) dated [DATE], Resident 1 was assessed as having no speech, rarely/never able to understand and rarely/never able to be understood. The MDS indicated Resident 1 received [MED] (a hormone made by the pancreas that allows your body to use sugar (glucose) from carbohydrates in the food that you eat for energy or to store glucose for future use) six of the last seven days. A review of the Weights and Vital Summary form indicated on [DATE] at 6:38 a.m., Resident 1's blood sugar was 410 mg/dl. A review of the Progress Note dated [DATE] indicated the physician was not notified of Resident 1's high blood glucose of 410, per physician's orders [REDACTED]. mg/dl blood sugar on [DATE]. A review of the Weights and Vital Summary form indicated from [DATE] at 10:56 a.m. - [DATE] at 8:39 p.m., Resident 1's blood sugar ranged from 311 - 374 mg/dl. A review of the Weights and Vital Summary form dated [DATE] indicated Resident 1's blood sugar was 350 mg/dl at 9 p.m. A review of the SBAR - Change of Condition Progress Note dated [DATE] at 10:50 p.m., indicated the respiratory therapist (RT) found Resident 1 unresponsive and immediately checked vital signs (blood pressure, pulse, temperature). The RT noted [MED]gen saturation (O2 sat, amount of [MED]gen in the blood) was low at 56% (normal between 80 and 100%), was unable to appreciate vital signs (obtain) at first attempt, as Resident 1 was found with cold, clammy skin. The SBAR form indicated Resident 1 was immediately bagged at 100% [MED]gen (a hand-held device commonly used to provide positive pressure ventilation to patients who are not breathing or not breathing adequately) which increased to 80%, but later dropped again. The RT was unable to wake Resident 1 who had a pulse rate reading of 0, heart rate reading of 0 and blood pressure reading of 0. The SBAR form indicated Cardiopulmonary Resuscitation (CPR) was started and resident revived, was able to open eyes, gags when suctioned, responds to stimuli, still could not appreciate vital signs, skin cold and clammy, bagged until paramedics arrived. Further review of the SBAR - Change of Condition Progress Note dated [DATE] indicated Instructions / Preparation on the SBAR were to evaluate finger stick glucose if indicated. A review of the Progress Notes indicated on [DATE] at 10:50 p.m., Resident 1 was bagged until paramedics arrived at 11:02 p.m., and took over. The progress note indicated Resident 1 was transferred to the General Acute Care Hospital (GACH) for further evaluation of altered level of consciousness. According to a review of the Emergency Documentation from the GACH, dated [DATE] at 11:29 p.m., Resident 1's chief complaint was altered level of consciousness (ALOC) and respiratory distress. The Subjective Nursing Assessment indicated Resident 1's last known well time (LWKT) was at 9 p.m. The document indicated Resident 1 was bagged (provided [MED]gen) by trachea (windpipe, allowing passage of air) and was not responsive. Two antibiotics were given for possible infection. No urine obtained on indwelling Foley catheter due to dehydration and found to be in acute [MEDICAL CONDITION] (kidneys unable to filter waste from blood) with [MEDICAL CONDITION] (increased potassium level in blood) for which calcium was given. Intensive Care Unit (ICU) consulted and Resident 1 was accepted into ICU. A review of the Emergency Documentation - MD Critical Care Note, dated [DATE] at 12:42 a.m., indicated Resident 1 had a critical condition, impending deterioration including: airway, cardiovascular (heart system), metabolic and renal with the associated risks factors of [MEDICAL CONDITION] (low blood pressure), metabolic changes, dehydration and acidosis (process causing increased acidity in the blood and other body tissues). The Emergency Documentation - MD Critical Care Note impression indicated Diabetic Ketoacidosis (DKA complication of diabetes the body produces excess blood acids), Acute Kidney Injury, [MEDICAL CONDITION] infarction (a [MEDICAL CONDITIONS] (high potassium in the blood). The Hospital Course indicated no surgery planned related to too unstable, seen by cardiology with no intervention due to too unstable, received blood transfusion, unstable for any other procedures. A review of the GACH Discharge Summary, dated [DATE] at 2:56 p.m., indicated the Discharge [DIAGNOSES REDACTED]. Patient was on ventilator support but [MEDICAL CONDITION] (a potentially life-threatening condition caused by the body's response to an infection) and expired despite maximum supportive measures. During an interview and concurrent record review of the medical record with the Director of Nursing (DON) on [DATE] at 3:12 p.m., she stated the physician should have been notified of Resident 1's elevated the blood glucose of 410 on [DATE]. The DON further stated the nurse may not have had time to take the blood glucose but agreed the blood glucose should have been taken prior to transport to the GACH. During an interview, on [DATE] at 4:20 p.m., the DON stated the SBAR documents were located in a different office, which indicated the physician was notified. These SBAR documents were not kept in Resident 1's medical record. The facility's policy and procedure titled, Diabetic Care, dated [DATE], indicated the purpose was to provide a protocol for the immediate treatment of [REDACTED]. The purpose indicated to improve the quality of care delivered to residents with diabetes. The policy procedure indicated, in any case where the resident's blood sugar was less than 70 mg/dl or greater than 350 mg/dl the Attending Physician must be notified; unless noted on the physician's orders [REDACTED]. The Attending Physician will be notified of a blood sugar level (BSL) lower than 70 mg/dl or greater than 350 mg/dl, unless otherwise indicated in the plan of care.

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.