STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055206	A. BUILDING _____ B. WING _____	**09/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRY VILLA PLAZA CONVALESCENT CENTER	**1209 HEMLOCK WAY SANTA ANA, CA 92707**

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 observation, interview, and medical record review, the facility failed to provide the necessary care and services for one of two sampled residents (Resident 2). * Resident 2 complained of pain to the left foot during a transfer by two staff employees (CNAs). The two CNAs failed to report the resident's complaint of pain to the licensed nurse, causing a delay in interventions and leaving Resident 2 with pain on the left foot for two days before an x-ray was ordered. Resident 2 sustained a fracture to the left distal fibula (the end of the two bones supporting the ankle joint). Findings: Review of the facility's P&P titled Incident Investigation revised 8/1/14, showed in the event of an incident, a licensed nurse or the individual who first encounters or witnessed an incident will report and document the incident. Medical record review for Resident 2 was initiated on 7/29/20. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of the history and physical examination [REDACTED]. On 7/29/20 at 1201 hours, an interview was conducted with Resident 2. Resident 2 stated in the evening of 7/10/20, when CNAs 1 and 2 were assisting her in transferring from wheelchair to bed, CNA 2 stepped on her left foot, and her foot twisted. Resident 2 stated both CNAs 1 and 2 heard her cry out in pain. Resident 2 stated CNA 1 left the room after the transfer, and CNA 2 told her not to tell anyone about her injury. Resident 2 stated she did not tell anyone after CNA 2 had told her not to tell. Resident 2 stated she did not tell anybody because she was afraid CNA 2 was angry with her. Resident 2 stated the incident made her frightened of CNA 2's action. Resident 2 stated she did not know what to do. She stated the situation had made her feel helpless and just prayed to God to deal with the pain. Resident 2 stated she had a heart condition and was worried if she got upset from the situation it could make her heart condition worse. Resident 2 stated she was in pain for two days until she got relief at the hospital. Review of Resident 2's medical record failed to show documentation the incident was reported to the licensed nurse. The medical record failed to show an investigation was conducted nor the physician was informed of the incident. Review of the Weekly Licensed Personnel Progress Notes showed the nursing entries on 7/11 and 7/12/20, showing Resident 2 continued to complain of the left leg and left foot/ankle pain, and was administered pain medication as ordered. Review of the Radiology Report dated 7/12/20, showed Resident 2 sustained a fracture to the left distal fibula. A dedicated evaluation of the ankle was recommended. On 7/29/20 at 1323 hours, an interview was conducted with the DON. The DON stated all staff were expected to report any accident, incident or changes of condition, like pain, to a supervisor or a charge nurse, no matter how insignificant. The DON stated the purpose of reporting was to provide correct information to the resident's physician, to ensure adequate treatment would be provided, and interventions for the resident would not be delayed. The DON stated upon knowledge of the incident, she conducted an investigation. The DON stated the outcome of her investigation showed Resident 2's account of the incident was credible. On 8/04/20 at 1058 hours, a telephone interview was conducted with LVN 1. LVN 1 stated he was the charge nurse assigned to Resident 2 on 7/10/2020, for the evening shift (1500 to 2300 hours). LVN 1 stated the CNAs were expected to report any accidents, injuries, or complaints of pain to him. LVN 1 stated he was unaware Resident 2 had been injured during a transfer on his shift because neither CNA 1 nor CNA 2 had reported to him about the left foot injury. LVN 1 stated he had assessed Resident 2 for a complaint of pain, and had provided the Resident 2 with pain medication as ordered. LVN 1 stated he reported the complaint of pain to Resident 2's physician, but did not ask for an X-Ray of Resident 2's left foot, as he was unaware of the injury. LVN 1 stated if CNA 2 had reported the incident to him, he would have been able to inform the doctor and ask for an X-Ray of the foot right after the incident occurred. LVN 1 verified the failure to report the injury to him had delayed Resident 2's treatment. On 8/4/20 at 1428 hours, a telephone interview was conducted with CNA 3. CNA 3 stated she was assisting Resident 2 on the night shift (2300 to 0700 hours) on 7/11/20, when Resident 2 complained to her of left leg pain. CNA 3 stated she saw Resident 2's left leg and it looked swollen. CNA 3 stated Resident 2 told her she had been injured during a transfer from her wheelchair to her bed on 7/10/20. Resident 2 reported her left foot had been stepped on by CNA 2, and CNA 2 had told the resident not to report it. CNA 3 stated Resident 2 had told her because she trusted her. CNA 3 stated she reported this information to the RN supervisor immediately on 7/12/20, during her shift. Attempts were made to to conduct an interview with CNA 2, however, CNA 2 refused to speak with the surveyor. On 8/21/20 at 1512 hours, a telephone interview was conducted with CNA 1. CNA 1 verified she worked on 7/10/20, and was familiar with Resident 2. CNA 1 stated she was not assigned to Resident 2 and was assisting CNA 2, when Resident 2 complained of pain on her left foot during the transfer. CNA 1 stated facility staff were expected to report pain immediately to their supervisor. CNA 1 stated Resident 2 was not her resident and it was the responsibility of CNA 2 and therefore, CNA 2 should have reported the incident, not her. CNA 1 verified she did not report the resident's complaint of pain on the left foot during transfer to a licensed nurse or a supervisor.

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