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 _____	**03/16/2020**

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 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its policy and procedure by not developing and implementing a care plan to address skin condition and pressure ulcers (bed sores) for one of 3 sampled residents (Resident 1). This deficient practice had the potential to result in inconsistent implementation of care and missed opportunities to identify any risk factors related to skin condition and pressure ulcer. Findings: A review of Resident 1's Admission Record indicated the resident was admitted to the facility on [DATE]. Resident 1's [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set ((MDS), a resident assessment and care screening tool), dated 1/5/20 indicated the resident had the ability to understand and be understood by others. The MDS, under Section M, indicated Resident 1 was at risk for developing pressure ulcers. A review of Resident 1's Wound Assessment Report, dated 1/2/20 indicated the resident had irritation/excoriation (an area on the surface of the skin that is torn or worn off) on the perineal area (the area between the tops of the thighs) and bilateral (affecting both sides) groin. The report indicated Resident 1's wound was macerated (softening and breaking down of skin resulting from prolonged exposure to moisture). A review of Resident 1's Wound Assessment Report, dated 1/2/20 indicated the resident had a [MEDICAL CONDITION] (open sore on the foot) located on the left second toe and left anterior (front of the body) second toe. A review of Resident 1's Wound Assessment Notes, dated 1/2/20, timed at 5:26 p.m., indicated the resident was at risk for deterioration (process of becoming worse) and further skin breakdown due to being incontinent (no control) of bowel and bladder. The Wound Assessment Notes indicated Resident 1 required maximum assist with activities of daily living, transfers, and bed mobility. During an interview on [DATE], at 3:55 p.m.,Medical Records Director (MRD) stated and confirmed that a care plan for skin/wound was not completed. During an interview on [DATE], at 4:12 p.m., Quality Assurance Nurse (QA) stated, for every physician's orders [REDACTED]. QA stated there should have been a care plan completed to address Resident 1's skin condition. A review of the facility's undated policy and procedure (P&P), titled Pressure Ulcer Risk Assessment, indicated, upon initial assessment, residents identified to be at risk will have a plan of care initiated to address the pressure ulcer risk factors including: protecting skin against the effects of pressure, friction and shear; protecting skin from moisture; encouraging optimal nutrition and fluid intake.
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 interview and record review, the facility failed to ensure one of 3 sampled residents (Resident 1) was assessed weekly for the presence of developing pressure ulcers and wounds (an injury to the skin or tissue over a bony area) according to its policy and procedure. This deficient practice had the potential to result in an increase in size of the wound/pressure ulcer, development of a new wound/pressure ulcer, and prevent healing of the wound/pressure ulcer on a medically compromised resident. Findings: A review of Resident 1's Admission Record indicated the resident was admitted to the facility on [DATE]. Resident 1's [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set ((MDS), a resident assessment and care screening tool), dated 1/5/20, indicated the resident had the ability to understand and be understood by others. The MDS, under Section M, indicated Resident 1 was at risk of developing pressure ulcers. A review of Resident 1's Wound Assessment Report, dated 1/2/20, indicated the resident had irritation/excoriation (an area on the surface of the skin that is torn or worn off) on the perineal area (the area between the tops of the thighs) and bilateral (affecting both sides) groin. The report indicated Resident 1's wound was macerated (softening and breaking down of skin resulting from prolonged exposure to moisture). A review of Resident 1's Wound Assessment Report, dated 1/2/20, indicated the resident had a [MEDICAL CONDITION] (open sore on the foot) located on the left second toe and left anterior (front of the body) second toe. A review of Resident 1's Wound Assessment Notes, dated 1/2/20, timed at 5:26 p.m., indicated the resident was at risk for deterioration (process of becoming worse) and further skin breakdown due to being incontinent (no control) of bowel and bladder. The Wound Assessment Notes indicated Resident 1 required maximum assistance with activities of daily living, transfers, and bed mobility. During an interview on [DATE], at 2:30 p.m., Licensed Vocational Nurse 1 (LVN 1) stated, wound assessment was done for Resident 1 on 1/2/20. LVN 1 stated, there should have been another wound assessment done the week after 1/2/20. LVN 1 confirmed she did not do a wound assessment the week after 1/2/20. During an interview on [DATE], at 3:29 p.m., Medical Records Director (MRD) stated, there should have been a wound assessment completed on 1/9/20. MRD confirmed the wound assessment was not completed in Resident 1's medical record for 1/9/20. During an interview on [DATE], at 4:12 p.m., Quality Assurance Nurse (QA) confirmed that wound assessments are to be done weekly and that there was not a wound assessment completed for Resident 1 on 1/9/20. A review of the facility's undated policy and procedure (P&P), titled Pressure Ulcer Risk Assessment, indicated, skin inspections will be assessed for the presence of developing pressure ulcers on a weekly basis or more if frequently indicated. Nurses will conduct skin inspections at least weekly to identify changes.

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