POC Accepted By 31331 ON 12/4/19 JW

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/20/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555397	A. BUILDING _____ B. WING _____	C 11/20/2019

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

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of a complaint. Complaint number: CA00656633 Representing the Department: HFEN # 31331. The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Four deficiencies were issued for complaint number CA00656633.	F 000	**Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in this statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Health and Safety code section 1280 and 42CFR et seq. This plan of correction constitutes the facilities credible allegation of compliance.**	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide the necessary care and services for two of three sampled residents (Resident 2 and 5) with high risk for or	F 686	**F 686 TREATMENT TO PREVENT /HEAL PRESSURE ULCER CFR(S) 482.25(B)(1)(I)(II)** For Resident #2, Licensed Nurse applied the heel protector immediately, and ordered foot cradle on same day of observation. 1-1 re-education by DON with treatment nurse LVN 1 was done on 10-09-19 regarding the importance of ensuring the preventative device is in place as ordered to prevent hindering the healing of resident pressure	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Acting Director | (X6) DATE: 11-20-19

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 686	Continued From page 1 with pressure injuries (PI - areas of damaged skin caused by staying in one position for too long which reduces blood flow to the area and cause the skin to die and develop a sore) to avoid development and worsening of a pressure injury. For Resident 2, the feet were not offloaded to reduce the pressure on an existing PI. For Resident 5, the alternating pressure (AP) mattress (provides pressure redistribution by filling and un-filling air cells within the mattress so that contact points with the body are reduced) settings failed to allow the mattress to meet the resident's needs. These deficient practices caused an increased risk in hindering the healing of the residents PI. Findings: a. A review of Resident 2's medical record indicated an admission on 10/2/19, with diagnoses including PI of sacral region, Stage IV. A review of Resident 2's Minimum Data Set (MDS - a standardized assessment and care-screening tool), dated 8/5/19, indicated the resident had cognitive impairment (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) and required extensive to total dependence (full staff performance every time) from staff for all activities of daily living ([ADLs] such as dressing, toileting, personal hygiene, and bed mobility) and had a pressure reducing device while in bed. A review of the Physician's Order, dated 10/2/19, indicated Resident 2 had a pressure injury to the	F 686	RN #1 set the low air loss to right setting based on resident current weight (alternating). DON did 1-1 in-service with RN #1on October 9 to re-educate on the proper settings of low air loss mattresses. DON and DSD did rounds on October 9, 2019 and found that there were no other residents observed who weren't properly positioned and had device in place as ordered for prevention of further skin breakdown and no other low air loss mattresses were improperly set. Nursing staff was in-serviced by DON on 10/9/2019, 10/10/19, 10/11/19, 10/12/19, 10/13/19, and 10/14/19, 10/28/19 on the importance of prevention of pressure and pressure management, interventions preventing further injury, determine high risk resident and implementation.	

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F 686	Continued From page 2 left and right heel. On 10/9/19, at 11:38 a.m., during an observation with Licensed Vocational Nurse 1 (LVN 1), Resident 2 was observed in bed in supine position (on the back) with bilateral foot protectors resting on the mattress. LVN 1 verified Resident 2's feet were not offloaded and the blankets were directly on Resident 2's toes. LVN 1 stated the feet needed to be offloaded to prevent worsening of the PI. A review of the facility's policy and procedure titled, "Pressure Ulcer Prevention," dated 8/13/19, indicated the facility would implement measures to prevent pressure ulcers, such as offloading (positioning). b. A review of Resident 5's medical record indicated an admission on 4/26/19, with diagnoses including dementia (chronic memory loss due to poor blood flow to the brain) and PI to the sacral area. A review of Resident 5's Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 8/2/19, indicated the resident had cognitive impairment (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) and required extensive to total dependence (full staff performance every time) from staff for all activities of daily living ([ADLs] such as dressing, toileting, personal hygiene, and bed mobility) and had a pressure reducing device while in bed.	F 686	DON in-serviced licensed staff on 10/9/19 regarding importance of setting the low air loss accurately, its function, indication and monitoring. Nursing staff was in-serviced by DON on 10/9/2019, 10/10/19, 10/11/19, 10/12/19, 10/13/19, and 10/14/19, 10/28 on the importance of setting the low air loss accurately, the functions of alternating, and static, the indication, and monitoring for preventing further injury, and delayed wound healing. During routine rounds license staff to assure preventative device for pressure is in place to prevent delayed in healing of pressure injuries and licensed staff to assure low air loss setting is set on alternating as preventative management to prevent delayed in healing of pressure injuries. Any deficient practice observed by licensed nurse regarding preventative measure will immediately addressed and report to DON and any trends to QAPI meeting. Completion October 28, 2019	

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F 686	Continued From page 3 A review of the Physician's Orders, dated 8/28/19, indicated to provide Resident 5 with proper functioning and setting low air loss mattress for wound management. On 10/9/19, at 12:39 p.m., during an observation, Registered Nurse 1 (RN 1) verified Resident 5 was observed in bed in supine position with the air mattress set on static mode (light illuminated). RN 1 stated the mattress should not be on static mode and should be on alternating pressure. According to an air mattress online manufacturer manual, the static mode makes the mattress provide a firm surface that makes it easier for the resident to be transferred or repositioned. The static mode prevents the patient from bottoming out when in a sitting position. The air mattress has usually two modes alternating and static mode, the required setting is alternating mode. The pump in alternating mode removes air from the alternating cylinders in the bed. This creates a wave motion which gently shifts the person's weight slightly. They have a cycle time, during which the air is completely changed out in each cell at least once. This cycle time can be adjusted, but the average choice is 10 minutes. (http://www.invacare.com/doc_files/1148137.pdf)	F 686		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(l) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of	F 695	**F 695 Respiratory/Tracheostomy Care and Suctioning CFR(s):483.25(i)**	

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F 695	Continued From page 4 practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to label and cover oxygen (O2) equipment for two of three sampled residents with oxygen (Resident 3 and 4). For Resident 3, the humidifier and nebulizer were not covered or dated, as indicated in the facility policy. For Resident 4, the physician's order for oxygen was not followed and the tubing was not changed, per facility policy. These deficient practices had the potential for a delay in providing oxygen or breathing treatments as ordered by the physician to the residents. Findings: a. A review of Resident 3's medical record indicated an admission to the facility, on 9/30/19, with diagnoses including chronic obstructive pulmonary disease (COPD - lung diseases that block airflow and make it difficult to breathe) and depression. On 10/9/19 at 11:52 a.m., during an observation and interview with Licensed Vocation Nurse 1 (LVN 1), Resident 3 was in bed with oxygen concentrator next to his bed. LVN 1 verified the humidifier attached to the oxygen concentrator had no date, and the nebulizer on the bedside dresser was exposed to open air, with no date. LVN 1 stated the oxygen therapy and treatment equipment was required to have a date and needed to be covered.	F 695	Res. 3's oxygen equipment, O2 humidifier and nebulizer, were immediately disposed of and replaced. A new bottle of humidifier with current date was connected to the concentrator for continuous use of oxygen as ordered. A new nebulizer was dated and placed in a set up bag with resident's name, room # & date. The set up bag with the nebulizer was closed and placed inside the drawer to keep from exposure to air and dust while not in use. Res 4's oxygen tubing was immediately removed and disposed of accordingly. A new oxygen tubing (nasal cannula) was dated and placed on resident for use with ordered oxygen flow at 2 LPM. Resident #4 was assessed by RT and O2 saturation was monitored to ascertain proper oxygenation during and after change of oxygen cannula. DON and RN/licensed nurse clarified order for O2 liter flow for continuous administration.	

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F 695	Continued From page 5 A review of the physician's order, dated 9/30/19, indicated to administer oxygen to Resident 3. The resident had the equipment for nine days without being changed. b. A review of Resident 4's medical record indicated an admission to the facility, on 8/8/19, with diagnoses including depression. On 10/9/19 at 12:02 p.m., during an observation and interview with Registered Nurse 2 (RN 2), Resident 4 was in bed with oxygen flowing at a rate of 2.5 liters per minute (L/min). RN 2 verified the oxygen tubing for Resident 4 was dated 8/26/19. A review of the physician's order, dated 8/8/19, indicated to administer oxygen at a rate of 2 L/min via nasal cannula for shortness of breath. According to the facility's policy and procedure titled, "Oxygen Administration," dated 7/1/15, indicated in order to provide oxygen to the tissues staff are required to follow physician orders, change oxygen tubing, humidifiers and mask on a weekly basis, and store them in plastic bag to protect the equipment from dust and dirt when not in use.	F 695	All nursing staff was re-educated and in-serviced on 10/9/19 by the Respiratory Therapist Manager on oxygen delivery devices including but not limited to nebulizers, nasal cannula, o2 humidifiers and the importance of following the facility's equipment changing schedule. Continuous re-education and in-service will be done by the RT Manager bi-monthly with all nursing staff regarding proper administration of oxygen, use of oxygen delivery devices and equipment changing schedule. Completion is October 10, 2019	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880	**F 880 INFECTION PREVENTION & CONTROL CFR(s):483.80(a)(1)(2)(4)€)(f)**	

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F 880	Continued From page 6 comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the	F 880	ICP began a monthly symptoms tracking log for the month of November 2019 to track signs and symptoms of possible infections to help identify any possible outbreak. ICP reviewed symptoms on the tracking log with no trends to lead to a potential outbreak noted. Signs and symptoms for potential infections will be monitored and reviewed monthly. ICP will review changes of condition daily (M-F) in morning meetings to possibly identify any potential sign or symptoms of infection. ICP will report to QA and QAPI monthly of any findings or unusual occurrences noted on the monthly symptoms tracking and trending. Completion is October 25, 2019	

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F 880	Continued From page 7 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain an infection control program designed to prevent the development and transmission of disease and infection, by failing to maintain and document on the monthly tracking surveillance logs to help identify patterns, rates, and possible outbreaks in the facility. This deficient practice had the potential to result in the transmission of disease and infection. Findings: On 10/9/19 at 1 p.m., during an interview and concurrent record review with the Director of Staff Development (DSD), she stated there were no monthly tracking logs maintained by the facility to	F 880		

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F 880	Continued From page 8 track signs and symptoms of possible infections to help identify possible outbreaks. According to the Centers of Disease Control and Prevention (CDC) recommendations, dated 6/19/17, long term care (LTC) facilities should track infections. Tracking infections help eliminate infections, many of which were preventable, improve care, and decrease costs. When facilities track infections, they can identify problems and track progress toward stopping infections. https://www.cdc.gov/nhsn/ltc/index.html A review of the facility policy and procedure titled, "Infection Prevention and Control Program," dated 1/1/17, indicated licensed staff should document signs and symptoms of suspected infections to identify outbreaks.	F 880		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to accurately implement the protocols using the Surveillance Data Collection Form, established by the facility, to	F 881	**F 881 Antibiotic Stewardship CFR(s):483.80(a)(3)** Surveillance Data Collection Form for Resident 6 was completed. Resident was admitted to the facility with a diagnosis of left hip wound infection. Resident met criteria for antibiotic use.	

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F 881	Continued From page 9 ensure two of three sampled residents (Resident 6 and 7) reviewed for the use of antibiotics met the criteria for the use of the treatment. Resident 6 was admitted to the facility with an antibiotic and the screening to meet criteria for the use of the treatment was not complete. For Resident 7, the screening indicated the resident did not meet criteria for the use of the antibiotic and there was no justification documented by the physician for the continued use. These deficient practices had the potential to result in the development of antibiotic-resistant organisms (not effective to treat infection), from unnecessary or inappropriate antibiotic use. Findings: a. A review of the Admission Record indicated Resident 6 was admitted to the facility, on 9/17/19, with admitting diagnoses of infection to the left hip. A review of Resident 6's Minimum Data Set (MDS - a standardized assessment and care-screening tool), dated 9/26/19, indicated the resident had no cognitive impairment and required extensive assistance from staff for activities of daily living. A review of the Surveillance Data Collection Form, dated 9/18/19, indicated Resident 6 was ordered Vancomycin (an antibiotic) 500 milligrams (mg) every 48 hours for six weeks. The area on the form to indicate if a culture was done for the use of the antibiotic remained blank. On 10/9/19 at 1 p.m., during an interview with the Director of Staff Development (DSD), she stated Resident 6 was administered Vancomycin and	F 881	Resident 7 and all residents who did not meet criteria were discussed in QA meeting held on 10/16/2019. All MDs in attendance agreed that if an MD would like to order or continue antibiotics for residents who do not meet criteria, MD must document reason in MD's progress notes ICP will monitor monthly antibiotic surveillance to acknowledge all residents who were prescribed antibiotics and did not meet criteria. If any residents were identified, ICP/licensed nurse will call MD to verify the need to continue antibiotic. ICP will monitor antibiotic surveillance sheets monthly. All residents (if any) who do not meet criteria will be audited for appropriate documentation from the doctor and/or nurse. License Nurses were in-serviced on 10/09/2019, 10/10/2019, 10/12/2019, and 10/14/2019 regarding importance of completing the Surveillance Date Collection form in its entirety each time an antibiotic order is received.	

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F 881	Continued From page 10 the required screening using the facility's McGeer criteria to ensure the indication of use for the treatment was not done. b. A review of the Admission Record indicated Resident 7 was readmitted to the facility, on 1/18/19, with diagnoses including, but not limited to, resistance to multiple antimicrobial drugs and sepsis. A review of the Surveillance Data Collection Form for Respiratory Tract Infection indicated three criteria must be present for Pneumonia: 1. Interpretation of chest radiograph 2. At least one of the respiratory sub-criteria such as cough, sputum, etc 3. At least one of the McGeer's criteria The McGeer's criteria was blank. On 10/9/19 at 1 p.m. during an interview with the Director of Staff Development (DSD), she stated the treatment for Resident 7 did not meet criteria for the use of the antibiotic and there was no documentation from the physician to justification the use for the treatment. According to the Centers for Disease Control and Prevention (CDC), there are identified core elements/actions a nursing home should ensure to prevent antibiotic resistance. The nursing home should: 1. Educate their providers on the potential harm of antibiotics 2. Document the meet criteria's for the use of the antibiotic and making this information accessible (e.g., verifying indication and planned duration is	F 881	ICP will continue monthly monitoring of Surveillance Date Collections Form to track residents (if any) who did not meet criteria. An audit will be done by ICP to ensure that all residents who do not meet criteria have the proper documentation or is discontinued, if appropriate. All reports will be presented at the monthly QA and QAPI meetings Completion is October 15, 2019	

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F 881	Continued From page 11 documented on transfer paperwork) helps ensure that antibiotics can be modified as needed based on additional laboratory and clinical data and/or discontinued in a timely manner to reduce unnecessary antibiotic exposure and improve resident outcomes. http://www.cdc.gov/longtermcare/pdfs/core-elements-antibiotic-stewardship-appendix-a.pdf	F 881		