STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056425	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45425 Based on interview and record review, the facility failed to ensure a resident, who lacked the capacity to make decisions and was conserved, was supervised, and monitored to prevent one of three sampled residents (Resident 1) from eloping (leaving a secured institution without notice or permission) from the facility. Resident 1 was last seen in the facility on 10/10/2024 at approximately 6:54 p.m. in his room. Resident 1 was noted missing on 10/10/2024 at approximately 7:57 p.m. Resident 1's Responsible Party (RP) informed the facility that she knew Resident 1's whereabouts at approximately 9 a.m., on 10/11/2024 This deficient practice resulted in Resident 1's eloping from the facility on 10/10/2024 and his whereabouts being unknown for approximately 14 hours. This deficient practice had the potential for Resident 1 to be exposed to excessive drops in temperature, motor vehicle accidents, hunger, dehydration, death and for 's Resident 1 to continue to be missing. Findings During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with the diagnoses including bipolar disorder (mood swings that range from the lows of depression to elevated periods of emotional highs) and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 1's History & Physical (H&P) dated 8/15/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set ([MDS] a federally mandated resident assessment tool) dated 9/8/2024, the MDS indicated Resident 1's cognition was intact and he required partial/moderate assistance (helper does less than half the effort) to complete his activities of daily living ([ADLs] routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1's Change of Condition (COC) note dated 10/10/2024 and timed at 7 p.m., the COC note indicated Resident 1 was last seen by Certified Nursing Assistant 1 (CNA 1) at 6:54 p.m., and she notified Licensed Vocational Nurse 1 (LVN 1) at 8 p.m., that she could not find Resident 1. The COC indicated staff searched for Resident 1 inside and outside the facility, but he was not found. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Nursing Notes, dated 10/14/2024, the Nursing Notes indicated on 10/11/2024 at 9 a.m., that Resident 1's RP came to the facility to pick up Resident 1's personal items and reported that Resident 1 was found in Westminster (approximately 16 miles away from the facility). During an interview on 10/24/2024 at 2:27 p.m., the facility's Receptionist stated she works from 2:30 p.m. until 8 p.m. Monday through Friday and when she takes her 10 minute break the Infection Prevention nurse (IPN), Director of Staff Development (DSD), or a licensed nurse monitors the front entrance. The Receptionist stated on 10/10/2024, she took a break around 7 p.m. but was unsure who monitored the front entrance while she was gone. The Receptionist stated around 8 p.m., she took another break but did not ask for any staff member to monitor the front desk, but stated she turned on the alarm for the front door. The Receptionist stated when she returned to the front desk, she heard the chaos of staff looking for Resident 1. During a telephone interview on 10/24/2024 at 3:25 p.m., LVN 1 stated on 10/10/2024 around 7:57 p.m., CNA 1 notified her that Resident 1 was not in his room. LVN 1 stated facility staff checked all rooms, bathrooms, under beds, and surrounding areas near the facility, such as parks, liquor stores and the metro station but they could not find Resident 1. During a telephone interview on 10/24/2024 at 4 p.m., CNA 1 stated Resident 1 was independent, kept to himself and usually stayed in his room. On 10/10/2024 around 7 p.m., she noticed Resident 1 was not in his room and she notified the charge nurse (LVN 1). During an interview on 10/10/2024 at 4:41 p.m., the Director of Nursing (DON) stated Resident 1 might have left through the front door because Resident 1 was much younger than other residents and the Receptionist might not have noticed him leaving through the front entrance. The DON stated the front entrance's alarm is not turned on until the Receptionist leaves at 8 p.m., it was possible that she (Receptionist) became distracted when she was on the phone and taking messages. During a review of the facility's policy and procedure (P/P) titled Wandering & Elopement dated 10/2023, the P/P indicated the facility will identify residents at risk for elopement and minimize any possible injury because of the elopement. During a review of the facility's Assessment Tool, dated 11/9/2023, the Assessment Tool indicated the facility must have sufficient staff members who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45425 Based on interview and record review, the facility failed to ensure one sampled resident (Resident 1) who was discharged from the facility, against medical advice ([AMA] a patient who leaves a medical facility before the physician recommends discharge) on 10/11/2024, and was no longer under the care of a physician at the facility, did not have a procedure performed on 10/14/2024 to remove a gastrostomy tube ([GT] a surgical opening fitted with a device to allow nutrition and medication to be administered directly to the stomach common for people with swallowing problems) in the Director of Nurses (DON) office. This deficient practice resulted in Resident 1 undergoing a procedure at a facility where he no longer resided and where he had no assigned physician or orders/instruction for care. This deficient practice had the potential for Resident 1 to experience side effects related to the procedure including pain and infection. Findings: During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including dysphagia (difficulty swallowing), and GT placement. During a review of Resident 1's History & Physical (H&P) dated 8/15/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set ([MDS] a federally mandated resident assessment tool) dated 9/8/2024, the MDS indicated Resident 1's cognition was intact and he required partial/moderate assistance (helper does less than half the effort) to complete his activities of daily living ([ADLs] routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1's Change of Condition (COC) note dated 10/10/2024 and timed at 7 p.m., the COC note indicated Resident 1 was last seen by Certified Nursing Assistant 1 (CNA 1) at 6:54 p.m., and she notified Licensed Vocational Nurse 1 (LVN 1) at 8 p.m., that she could not find Resident 1. During a review of Resident 1's Nursing Note, dated 10/14/2024, the Nursing Notes indicated on 10/11/2024 at 9 a.m., Resident 1's Responsible Party (RP) came to the facility to pick up Resident 1's personal items and reported that Resident 1 was found in the city of Westminster, and she would be signing Resident 1 out AMA. The Nursing Note indicated on 10/14/2024 (time unknown), the RP returned to the facility with Resident 1 to have his GT removed because Resident 1 did not want to go to a General Acute Care Hospital (GACH) and felt safer coming to the facility. The Nursing Note indicated Resident 1's GT was removed by Resident 1's physician's, Physician Assistant ([PA] a health care professional who works under the supervision of a physician to provide medical treatment) in the Director of Nursing's (DON) office. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/24/2024 at 5 p.m., the DON stated Resident 1's RP was concerned about Resident 1 having his GT in place while out on the street. The DON stated she wanted to ensure Resident 1 was safe and thought it was the best option for Resident 1 to have his GT removed at the facility. During a review of the facility's policy and procedure (P/P) titled Admission and Orientation of Residents dated 1/2024, the P/P indicated the facility will only admit residents in need of skilled nursing and/or long-term care placement upon the order of an Attending Physician.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45425 Based on interview and record review, the facility failed to ensure medications, Ciprofloxacin hydrochlorothiazide (HCL) (a medication used to treatment bacterial infections), Mupirocin 2% ointment (a medication used to treat skin infections caused by bacteria), Triamcinolone 0.1% cream (a medication used to relieve redness, itching, swelling or other discomfort caused by skin conditions), Hibiclens 4% foam (a skin cleanser which helps reduce bacteria), and Ammonium Lactate 12% topical cream (a skin cream that treats dry skin) prescribed following dermatology visits on 9/20/2024 and 10/18/2024, and delivered to the facility on the same dates, were administered as ordered to one of three sampled residents (Resident 2) to treat Resident 2's statis dermatitis (a skin condition that occurs when blood pools in the veins of the lower legs, causing skin changes due to poor circulation). This deficient practice resulted in the delayed administration of medications and treatment of Resident 2's statis dermatitis and had the potential for non-healing and or increase to Resident 2's skin condition. Findings During a review of Resident 2's Admission Record (Face Sheet), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with a diagnosis of cellulitis (deep infection of the skin caused by bacteria) of the right and left lower limb. During a review of Resident 2's Minimum Data Set ([MDS] a federally mandated resident assessment tool) dated 9/2/2024, the MDS indicated Resident 2's cognition (the mental process of thinking, learning, remembering, and using judgement) was intact. During a review of Resident 2's Dermatology office visit note dated 10/22/2024, the Dermatology office visit note indicated on 9/20/2024 Resident 2 was prescribed Ciprofloxacin hydrochlorothiazide HCL, Mupirocin 2% ointment, Triamcinolone 0.1% cream, and Hibiclens 4% foam. During a review of Resident 2's Dermatology office visit note, dated 10/18/2024, the Dermatology office visit note indicated Resident 2 was prescribed Ammonium Lactate 12% topical cream. During a review of the facility's Pharmacy Delivery Receipt dated 9/20/2024, the Pharmacy Delivery Receipt indicated Ciprofloxacin HCL 500 mg 28 tablets, Mupirocin 2% ointment, Triamcinolone 0.1% cream, and Hibiclens 4% with foam pump were delivered to the facility on [DATE]. During a review of Resident 2's Medication Administration Record (MAR) for the month of 9/2024, the MAR indicated Ciprofloxacin 500 mg one tablet was administered beginning 9/26/2024 (six days after the order was prescribed and the medications were delivered). During a review of Resident 2's Treatment Administration Record (TAR) dated 10/2024, the TAR indicated Ammonium Lactate 12% topical cream was applied to Resident 2's left lower leg beginning 10/23/2024 (five days after the medication was prescribed). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/24/2024 at 9:54 a.m., and a subsequent interview at 10:21 a.m., Licensed Vocational Nurse 4 (LVN 4) stated on 9/26/2024, after Resident 2 inquired about the medications the dermatologist prescribed after his most recent visit (9/20/2024), she found the Hibiclens in the medication room and the Mupriocin in one of the medication carts. LVN 4 stated the Triamcinolone 1% cream was found by the other treatment nurse (LVN 2) on 9/29/2024. LVN 4 stated she was unaware of the total amount of medications that were prescribed by the dermatologist, and the medications should have been given to Resident 2 on 9/20/2024 after they were delivered by the Pharmacy. LVN 4 stated she did not find the Ammonium lactate until 10/23/2024 in the second drawer of the medication cart with other creams, she then called the pharmacy to clarify because there was no physician's order or progress notes in the chart to indicate why the medication was ordered and delivered to the facility for Resident 2. LVN 4 stated if medications were not administered as prescribed, the healing process could be delayed. During an interview on 10/24/2024 at 10:13 a.m., Licensed Vocational Nurse 3 (LVN 3) stated when Resident 2 returned from his dermatology appointment on 10/18/2024, there were no orders sent back with Resident 2 and she (LVN 3) did not call the physician office to confirm that there were no new orders or to obtain a copy of the consultation notes. LVN 3 stated when the medications were delivered from the pharmacy, they should have been verified against the physician's order. LVN 3 stated any medication specifically for treatments are held in a designated place until the medication can be physically given to the treatment nurse to be placed in the medication cart. During an interview on 10/24/2024 at 11:17 a.m., Registered Nurse Supervisor 1 (RNS 1) stated Ciprofloxacin was ordered on 9/26/2024 when she called the dermatologist office for the order. RNS 1 stated she found out the medication was delivered to the facility on [DATE] and should have been administered to Resident 2 as soon as it was delivered. During an interview on 10/24/2024 at 4:41 p.m., the Director of Nursing (DON) stated when medications are delivered from the pharmacy, the receiving licensed staff should ensure all medications are accounted for by comparing the delivery report and medication package that was delivered. The DON stated there was no system in place to verify when medications are delivered from the pharmacy, to compare/verify them against the residents' physician's orders. The DON stated when the medications are delivered, the receiving licensed staff should put them away in the correct place. During a review of the facility's policy and procedure (P/P) titled Medication-administration dated 10/2023, the P/P stated medication will be administered by a Licensed Nurse per the order of an attending physician or licensed independent practitioner.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45425 Based on interview and record review, the facility failed to ensure the consultation notes for an outside of the facility dermatology visit were readily available in the medical record for one of three residents (Resident 2). This deficient practice resulted in the delayed treatment of Resident 2's statis dermatitis (a skin condition that occurs when blood pools in the veins of the lower legs, causing skin changes due to poor circulation), administration of Ammonium Lactate 12% topical cream (a skin cream that treats dry skin), and non-continuity of care. This deficient practice had the potential for Resident 2's skin condition to not heal and/or worsen. Findings During a review of Resident 2's Admission Record (Face Sheet), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with a diagnosis of cellulitis (deep infection of the skin caused by bacteria) of the right and left lower limb. During a review of Resident 2's Minimum Data Set ([MDS] a federally mandated resident assessment tool) dated 9/2/2024, the MDS indicated Resident 2's cognition (the mental process of thinking, learning, remembering, and using judgement) was intact. During a review of Resident 2's Physician order dated 9/21/2024, the Physician order indicated Resident 2 had a dermatology appointment on 10/18/2024 at 11:15 a.m. During a review of Resident 2's Progress Notes dated 10/18/2024 and timed at 10 a.m., the Progress Notes indicated Resident 2 left for his appointment in stable condition. During a review of Resident 2's Progress Notes dated 10/18/2024 and timed at 14:30 p.m., the Progress Notes indicated Resident 2 returned to the facility from his appointment with no new orders. During a review of Resident 2's clinical record, the clinical record indicated, there was no documentation of or availability of Resident 2's dermatology consultation note. During an interview on 10/24/2024 at 10:13 a.m., Licensed Vocational Nurse 3 (LVN 3) stated when Resident 2 returned from his dermatology appointment on 10/18/2024, there were no orders sent back with Resident 2 and she (LVN 3) did not call the physician office to confirm that there were no new orders or to obtain a copy of the consultation notes. During an interview on 10/24/2024 at 4:41 p.m., the Director of Nursing (DON) confirmed Resident 2's dermatology consultation notes were not available for review and stated if consultation notes were not received and staff did not follow up to obtain the notes, there was a risk that treatment and medications could be missed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P/P) titled General Provisions dated 10/2023, the P/P indicated records, either originals or accurate reproductions will be maintained in such a form to be legible and readily available upon the request of the attending physician, facility staff or any authorized officer.