Department of Health & Human Services
Centers for Medicare & Medicaid Services

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555726 | A. Building<br>B. Wing | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mar Vista Country Villa Healthcare & Wellness | 3966 Marcasel Ave<br>Los Angeles, CA 90066 |

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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43321<br><br>Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 4) was monitored and supervised to prevent fall and injuries as evidenced by failing to:<br><br>1. Ensure Resident 4's bed was in low position based on Resident 4's fall care plan and physician order.<br><br>2. Ensure Resident 4 had floor mats based on Resident 4's fall care plan and physician order.<br><br>3. Ensure Resident 4 was not left unattended by Certified Nursing Assistant 4 (CNA 4) while the bed was in high position , and the bed rails (also called side rails; are adjustable metal or rigid plastic bars that attach to the bed. They are available in a variety of types, shapes, and sizes ranging from full to one-half, one-quarter, or one-eighth lengths) are in position (on).<br><br>These deficient practices resulted in Resident 4 had a fall sustaining a head injury and laceration (a deep cut or tear in skin or flesh) to the left eyebrow on 5/6/2024 where she was transferred to General Acute Care Hospital 1 (GACH 1).<br><br>Findings:<br><br>A record review of the Admission Record (Face Sheet) indicated Resident 4, was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included muscle weakness, disorder of bone density (amount of bone mineral in the bone) and structure, cachexia (a general state of ill health involving great weight loss and muscle loss), hypertension (high blood pressure), and malignant neoplasm (cancer tumor) of the thymus (a small organ that lies in the upper chest under the breastbone).<br><br>(continued on next page) |

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.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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F 0689

Level of Harm - Actual harm

Residents Affected - Few

A record review of Resident 4's Bed Rail Assessment, dated 9/30/2023, indicated Resident 4's level of consciousness fluctuates (rise and fall irregularly). The Bed Rail Assessment indicated Resident 4 had an altered safety awareness due to cognitive (involve the ability to acquire factual information) decline, had displayed poor mobility or difficulty moving to a sitting position on the side of the bed, and had difficulty with balance or poor trunk control (ability to hold the body upright when sitting or moving). The Bed Rail Assessment indicated interventions to lower the bed to the floor and provide restorative care to enhance Resident 4's abilities to safely stand and walk. The Bed Rail Assessment indicated side rail placement recommendations of bilateral (both sides) side rails, which are indicated to serve as an enabler to promote independence.

A record review of Resident 4's Fall Risk Evaluation, dated 1/11/2024, indicated Resident 4 scored an 8. The evaluation indicated that a total score of 10 or higher identifies the resident as a high risk for potential falls.

A record review of Resident 4's Minimum Data Set (MDS, a comprehensive assessment tool), dated 4/3/2024, indicated Resident 4 had severe cognitive impairment. The MDS also indicated Resident 4 was dependent on staff (helper does all effort. Resident does none of the effort to complete activity. Assistance of two or more helpers are required for the resident to complete the activity) on eating, oral hygiene, toileting, bathing, upper body dressing, lower body dressing, putting on and taking off footwear and personal hygiene. The MDS also indicated Resident 4 was dependent on staff when changing positions from rolling left and right, sitting to lying, lying to sitting on side of bed, bed to chair transfer, toilet transfer, and shower transfer.

A record review of Resident 4's Physician Order, dated 3/27/2024, indicated an order for floor mat with low bed. The order identified Resident 4 as fall risk.

A record review of Resident 4's care plan titled Resident on low bed with floor mat to decrease potential risk for injury, initiated on 4/15/2024, indicated a goal to prevent fall and injury until the next review date of 7/2/2024. The care plan indicated interventions of providing Resident 4 with frequent supervision and to provide Resident 4 a low bed with floor mats as ordered.

A record review of Resident 4's care plan titled The resident has impaired cognitive function / or impaired thought process r/t (related to) difficulty making decisions, impaired decision making, psychotropic (drug or other substance that affects how the brain works) drug use, BIMS (Brief Interview for Mental Status; a mandatory tool used to screen and identify the cognitive condition of residents) score of 6, (score of 6 indicates severe cognitive impairment), initiated on 4/15/2024, indicated a goal for Resident 4 to maintain current level of cognitive function through the review date of 7/2/2024. One of the interventions included in the care plan is to cue, reorient and supervise Resident 4 as needed.

A record review of Resident 4's care plan titled The resident has an alteration in musculoskeletal (part of the body that includes the muscle, bones, ligaments and tendons) status r/t (related to) disorder of bone density and structure, cachexia initiated on 4/15/2024, indicated a goal for Resident 4 to remain free of injuries or complications until the next review date of 7/2/2024. Interventions included in the care plan was to anticipate and meet Resident 4's needs, to be sure call light is within reach, to respond promptly to all of Resident 4's requests for assistance, to monitor and document for risk of falls and to educate resident, family and caregivers on safety measures that need to be taken in order to reduce risk of falls.

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A record review of Resident 4's Situation, Background, Assessment and Recommendation (SBAR, a tool used to facilitate prompt and appropriate communication between the healthcare team) Communication Form and Progress Note, dated 5/6/2024, indicated Resident 4 had a change in condition of fall. The SBAR Communication Form indicated Resident 4 was found on the floor with a laceration to the left eyebrow and hematoma (a mass of usually clotted blood that forms in a tissue, organ, or body space) to the right eyebrow. Resident 4 was assessed and sent to GACH 1 via emergency medical transport.<br><br>A record review of Resident 4's Skilled Nursing Facility (SNF) to Hospital Transfer Form, dated 5/6/2024, indicated Resident 4 was transferred to GACH 1 on 5/6/2024 at 11:05 am because of a fall. The SNF to Hospital Transfer Form indicated Resident 4 was totally dependent on staff on all ADLs ( Activities of Daily Living) including bathing, dressing, toileting, transfers and eating.<br><br>A record review of the Emergency Department Provider Note, dated 5/6/2024 at 11:19 am, indicated Resident 4 was diagnosed with head injury and a laceration of the left eyebrow. The physical assessment part of the note indicated a 1-centimeter (cm, unit of measurement) laceration to the left eyebrow. Resident 4 underwent a Computed Tomography scan (CT, a medical imaging scan used to obtain detailed internal images of the body) of the head and spine and X rays (medical imaging that creates pictures of bones and soft tissues, such as organs) of both humerus (bone of the upper arm) and was treated with a laceration repair where she received three sutures (a strand or fiber used to sew parts of the living body).<br><br>A record review of Resident 4's CT of the head result from GACH 1, dated 5/6/2024, indicated frontal scalp soft tissue swelling.<br><br>A record review of Resident 4's Post Fall Risk evaluation, dated 5/6/2024, indicated Resident 4 scored an 11. The evaluation indicated that a total score of 10 or higher identifies the resident as a high risk for potential falls.<br><br>A record review of Resident 4's Post Fall Evaluation, dated 5/6/2024, indicated Resident 4 had an unwitnessed fall in her room that resulted to an injury of laceration to the left eyebrow and hematoma above her right eyebrow. The Post Fall Evaluation identified the improper height of the bed as one of the contributing factors of the fall. The Post Fall Evaluation indicated there was no floor mat on the floor. The Post Fall Evaluation also indicated Resident 4 complained of pain and exhibited facial expressions of pain to the head after the fall.<br><br>A record review of Resident 4's Health Status Note, dated 5/6/2024, indicated Resident 4 returned to the facility from GACH 1 with three stitches on the left eyebrow / forehead.<br><br>A record review of Resident 4's Weekly Skin/ Wound Assessment, dated 5/6/2024, indicated Resident 4 returned from GACH 1 with three (3) stitches in the left eyebrow / forehead, discoloration with hematoma in the center forehead, discoloration on the right eye, multiple discoloration on the left arm, multiple discoloration on the right arm with scab and right shin (front parts of your legs between knees and ankles) scratch.<br><br>A record review of Resident 4's Health Status Note, dated 5/7/2024, indicated Resident 4 returned to the facility from GACH 1 with a left eyebrow laceration with three sutures, right periorbital (around the eyes) discoloration, forehead hematoma, right upper extremity (right arm) and left upper extremity (left arm) discoloration and a right forearm skin tear measuring at 1.1 cm x 0.3 cm.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A record review of Resident 4's Physician Orders, dated 5/7/2024, indicated the orders of: [Treatment] L (left) eyebrow laceration w/ (with) sutures: Cleanse with NSS (normal saline solution, a cleansing solution made up of water and salt), pat dry and LOA (leave open to air) every day shift for 14 days and [Treatment] R (right) forearm skin tear: Cleanse with NSS, pat dry, apply xeroform (a petrolatum-based fine mesh gauze containing 3% bismuth tribromophenate [Medication that has antimicrobial properties]), and cover with foam dressing every day shift for 14 days.<br><br>A record review of Resident 4's Progress Note, dated 5/7/2024 at 5:19 am, indicated Resident 4 complained of pain of 3/10. Resident 4 refused pain medications but was offered ice pack on her forehead for comfort measures.<br><br>A record review of Resident 4's Interdisciplinary Progress Note (IDT, a group of healthcare professionals from various areas working together to set goals and make decisions) for Fall, dated 5/7/2024, indicated that the IDT met to discuss Resident 4's fall on 5/6/2024. The IDT Note indicated Resident 4 rolled out of bed after the CNA (later identified as Certified Nursing Assistant 4) provided ADL care. The IDT note indicated CNA 4 placed Resident 4 in the center of the bed, placed a fourth of the side rails up and went to the doorway to call for help with repositioning Resident 4 when suddenly Resident 4 was found on the floor next to her bed. The IDT note indicated CNA 4 immediately called for help and Resident 4 was assessed and was transferred to GACH 1 for evaluation. The IDT note indicated Resident 4 has behaviors of aggressions, striking at staff and moving abruptly. The IDT note indicated The IDT believes the resident was possibly angry regarding having care provided and moved abruptly in her bed due to her feelings and suddenly came off her bed.<br><br>During an interview on 6/5/2024 at 2:50 pm, Resident 3 stated Resident 4 fell on [DATE] around 10 am in the morning. Resident 3 stated a curtain is separating her and Resident 4 when she heard a bang. Resident 3 pulled the curtain divider and saw Resident 4 on the floor, on the right side of the bed between the bed and the wall. Resident 3 stated she observed Resident 4's head bleeding after the fall. Resident 3 stated when Resident 4 fell , the side rails were up and not down, and the bed was also high because CNA 4 was changing Resident 4 before the fall happened. Resident 3 stated at the time of the fall, Resident 4 did not have floor mats beside her bed. Resident 3 stated Resident 4 left the facility to the hospital and came back with a right black eye and a cut on her left eyebrow. Resident 3 stated she is disappointed because Resident 4 fell because staff left her.<br><br>During an interview on 6/5/2024 at 3 pm, Responsibly Party 1 (RP 1) stated the facility informed her of Resident 4's fall on 5/6/2024 at 11 am. RP 1 stated she visits Resident 4 every day and she has not seen floor mats placed beside her bed before the fall. RP 1 confirmed they were placed after the fall. RP 1 stated she observed Resident 4 withdrawn after the fall. RP 1 stated she believes the fall could have been prevented if two assistants were present when changing Resident 4 and if the side rails were not left up (not in position).<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 6/5/2024 at 4:20 pm, Licensed Vocational Nurse 3 (LVN 3) stated and confirmed Resident 4 fell out of her bed on 5/6/2024. LVN 3 stated she heard a loud bang and went to Resident 4's room where she found Resident 4 on her back in between her bed and the wall. LVN 3 confirmed Resident 4 did not have floor mats and the height of the bed was high at hip level because CNA 4 was changing the resident before the fall. LVN 4 stated she observed Resident 4 was bleeding from her left eyebrow due to a laceration. LVN 4 stated when Resident 4 came back from GACH 1, she also observed Resident 4 with a black eye (discoloration) on her right eye and a bump on the middle of her forehead. LVN 3 stated she asked CNA 4 what happened and CNA 4 informed her she (CNA 4) stepped out of the room when Resident 4 fell . LVN 3 stated Resident 4's bed side rails should have been down and the height of the bed should be low. LVN 3 stated she believes the fall could have been prevented if CNA 4 placed the side rails in position. LVN 3 further stated that instead of leaving Resident 4, CNA 3 could have yelled for help.<br><br>During a phone interview on 6/5/2024 at 5:03 pm, CNA 4 stated Resident 4 fell on [DATE]. CNA 4 stated It was really a mistake on my end. CNA 4 stated she had Resident 4's bed high while changing Resident 4 during incontinent care. CNA 4 stated after changing Resident 4, she stepped away from Resident 4's bedside to the door to ask for help to pull up (reposition) Resident 4. While waiting for someone to help, CNA 4 stated Resident 4 was kicking to the side of the bed, which prompted her to reposition Resident 4's leg back to the middle of the bed. CNA 4 stated while she was at the door, Resident 4 fell . CNA 4 stated she believes Resident 4 turned over while trying to kick and then fell . CNA 4 confirmed the height of the bed was high and the side rails were up. CNA 4 stated Resident 4 was screaming after the fall. CNA 4 stated Resident 4 also had a cut on her forehead and was bleeding after the fall. CNA 4 stated Resident 4's fall could have been prevented if she placed the side rails down and if she lowered the bed close to the floor for safety. CNA 4 stated it is important to have the side rails down and the bed low to prevent falls and to prevent the resident from rolling out of bed.<br><br>During an interview on 6/5/2024 at 5:32 pm, the Interim Director of Nursing (IDON) stated a resident's height of the bed should be low and side rails down (in position) to ensure safety. The IDON stated side rails aid with mobility and repositioning. The IDON also stated side rails help with repositioning changes so residents do not slide out of bed. The IDON stated the bed being low is important so if the residents slide out of bed, the impact, which the IDON defined as the contact of the body to the floor, would be less.<br><br>During a follow up interview on 6/5/2024 at 6:20 pm, CNA 3 stated the side rails is not the usual side rails set up that we used, if say the side rails are up, the resident can fall; while say if the side rails are down it protects the resident from rolling out of bed. CNA 3 stated leaving the side rails up defeats the purpose of protecting the resident from falling.<br><br>A review of the facility's policy titled Fall Management Program, reviewed on 5/17/2023, indicated that the facility will provide residents a safe environment that minimizes complications associated with falls.<br><br>A review of the facility's policy titled Resident Safety, reviewed on 5/17/2023, indicated that the purpose of the policy is to provide a safe and hazard free environment to the residents. The policy indicated that after a risk evaluation is completed, a resident-centered care plan will be developed to mitigate safety risk factors.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A record review of the facility's policy titled Physician Orders, reviewed on 5/17/2023, indicated Whenever possible, the licensed nurse receiving the order will be responsible for documenting and carrying out the order. |