

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035298	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/26/2024
NAME OF PROVIDER OR SUPPLIER Welbrook Yuma Opco LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2271 South Ridgeview Drive Yuma, AZ 85364	

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)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47954</p> <p>Based on clinical record reviews, facility documentation, resident and staff interviews, and policy review, the facility failed to ensure that one resident (#50) was free from preventable pressure related injuries. The deficient practice could lead to other resident's developing preventable injuries.</p> <p>Findings include:</p> <p>-Resident #50 was admitted to the facility on [DATE], with diagnoses that include osteoarthritis, weakness, depression, rheumatoid arthritis, and a left knee replacement.</p> <p>A care plan initiated on August 11, 2024 revealed the resident was at risk of altered skin integrity as evidenced by decreased mobility with a goal of the resident having no new alterations in skin integrity, with noted interventions of notifying the doctor for any changes.</p> <p>Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident had no cognitive impairment.</p> <p>A review of the clinical record progress notes for resident #50 dated August 7, 2024 at 10:32 a.m. revealed resident #50 is having pain to left lateral side of leg. Upon arrival resident had ted hose on pulled down to calf area, stated ted hose had rolled down to knee area and have caused discomfort, noted popped blister to area.</p> <p>Another skin care plan added August 7, 2024 revealed the resident has an open blister to left lateral leg, with a goal of being free from infection through the review date and noted interventions of monitor and document size and treatment, as well as report abnormalities, failure to heal, and signs and symptoms of infection.</p> <p>A second progress note dated August 12, 2024 at 2:07 p.m. revealed that resident #50 continues with open blister to left lateral leg, provider updated regarding scant slough noted to lateral leg. Received ok to place mepilex ag and foam and continue to monitor.</p> <p>A third progress note dated August 13, 2024 at 10:50 a.m. revealed that the resident #50 acquired a pressure sore that was noted to left knee. The note stated resident #50 was seen by her ortho doctor. The note stated to Continue to ED for I&D (Incision & Drainage) of stage 3 pressure sore.</p> <p>(continued on next page)</p>

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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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with a Nurse Practitioner (NP/staff #15) on August 26, 2024 at 2:40 p.m. The NP stated that resident #50 was sent to the skilled nursing facility on August 1, 2024, and seen for a follow up outpatient on August 13, 2024. The NP stated that when resident #50 was seen for the follow up that she was readmitted and taken into surgery same day because of how bad resident #50's pressure injury was on examination. The NP also stated the wound was also infected and required antibiotic treatment. The NP further concluded that the resident is presently following up with infectious disease and required a wound vac for proper healing. The NP concluded that when the injury was reported to their office, the skilled nursing staff reported it was just a blister. The NP stated it was clearly not a blister as it required multiple treatments and surgical intervention.</p> <p>An interview was conducted with a Licensed Practical Nurse (LPN/staff #35) on August 26, 2024 at 3:20 p.m. The LPN stated that the reported incident involved a physical therapy staff member reporting the resident was complaining about her knee. The LPN further stated that when she examined the resident it looked like a big fluid filled blister. However, the LPN also stated that they do not have a wound certification.</p> <p>An interview with a Nurse Practitioner (NP/staff #17) was conducted on August 26, 2024 at 3:55 p.m. The NP stated that they were upset by the situation because it's a big deal. The NP further stated that when they were contacted on August 7, 2024 about the injury, it was described as a blister getting a little red. However, the NP further stated when they examined the resident, was not an accurate assessment on the part of the nursing staff. The NP stated that it appeared to be an infection of concern. The NP concluded that it was the ted hose that was the issue, specifically that it was too tight of a ted hose that was used.</p> <p>An interview with the Certified nursing assistant (CNA/staff #22) was conducted on August 26, 2024 at 4:25 p.m. The CNA stated that resident #50 was there for a knee replacement, and that the resident was alert and oriented and able to make her needs known. The CNA stated that the resident did have ted hose and stated the CNA's applied the ted hose in the morning.</p> <p>An interview with the Director of Nursing (DON/staff #5) was conducted on August 26, 2024 at 5:30 p.m. The DON stated that the resident developed a blister while she was here and that it got worse. The DON further stated that her wound nurse notified her of the wound, and notified the provider for instructions. The DON concluded that her expectation is that nurses document accurately what happens to the residents, as well as letting the provider and the surgeon know of changes that occur, especially when it's a surgical incision.</p> <p>Review of information received from the SA complaint tracking system revealed that on August 13, 2024, at 4:08 p.m. a clinical provider reported the resident was readmitted to the hospital for surgical debridement, wound closure and wound vac application for a stage 3 pressure ulcer on the resident's left leg, that the facility did not communicate with the surgeon that operated on the resident initially, and that this negligence let to patient harm as evidenced by this injury.</p> <p>A review of facility policy titled 'Pressure Ulcers / Injuries Overview' revised July 2017, revealed that avoidable means that the resident developed a pressure injury and that one of the following was not completed.</p> <p>- Evaluation of the resident's clinical condition and risk factors;</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - Definition or implementation of interventions that are consistent with resident needs, resident goals, and professional standards of practice; - Monitoring or evaluation of the impact of the interventions; - Revision of the interventions as appropriate. <p>A review of facility policy titled 'abuse and neglect - clinical protocol' revised March 2018 revealed the nurse will report findings to the physician. As needed, the physician will assess the resident/patient to verify or clarify such findings, especially if the cause or source of the problem is unclear.</p>