STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055191	A. Building B. Wing	06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Madera Care Center	1700 Howard Road Madera, CA 93637

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 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. 44708 Based on interview and record review, the facility failed to maintain complete and accurate medical records for one of three residents (Resident 1) when Resident 1 was admitted with a stage 3 pressure ulcer (damage to an area of the skin caused by constant pressure on the area for a long time through the skin into deeper tissue and fat but do not reach muscle, tendon, or bone) to the sacral (tailbone) region on 4/17/24 and Resident 1 ' s stage 3 pressure ulcer assessment was not documented (a process used to learn about a patient's condition) until 5/14/24. This failure was not the standard of practice according to the facility ' s policy and procedure titled, Charting and Documentation, and Prevention of Pressure Injuries. Findings: During a review of Resident 1 ' s Admission Record (AR), dated 6/19/24, the AR indicated Resident 1 had a stage 3 pressure ulcer to the sacral region. During a review of Resident 1 ' s Admission/Readmission Evaluation (ARE), dated 4/17/24, the ARE indicated, 4a. Is a skin issue present? Yes. Site: Sacrum. Description: Stage III (3) pressure ulcer. During a review of Resident 1 ' s IDT Skin Meeting (ISM), dated 4/24/24, the ISM indicated, Reason for Meeting: Open area to coccyx (tailbone). During a review of Resident 1 ' s Progress Report (PR), dated 5/14/24, the PR indicated, Wound Details: Location: Center Midline Coccyx. Classification: Pressure Ulceration. Stage: Stage III. Width: 7.5 cm (centimeters; unit of measurement). Length: 6 cm. Depth: 0.1 cm. Area 4.5 cm2 (centimeter squared; unit of measurement). Volume: 4.5 cm2. During an interview on 6/19/24 at 12:11 p.m. with Registered Nurse (RN), RN stated she was the designated wound nurse on the weekend. RN stated she provided wound treatment and wound assessment weekly for residents with wounds. RN stated she provided wound care and wound assessment for Resident 1. RN stated she was unable to locate the wound assessment record with measurements of the wound she completed for Resident 1 from 4/17/24 through 5/13/24. RN stated wound assessments with measurements of the wounds were required to record the condition and progress of the wound. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/9/24 at 3:42 p.m. with Physician Assistant (PA), PA stated she visited residents with wounds at the facility once a week. PA stated Resident 1 was referred to her on 5/14/24 with an open area to her coccyx. PA stated Resident 1 ' s wound was fully covered in eschar (dead tissue that forms over healthy skin and then, over time) during the first assessment. PA stated weekly assessments of the wound was required as proof of care. PA stated wounds should be measured and photographed to determine the progress of the wound. PA stated medical records should be complete and accurate. During an interview on 7/11/24 3:14 p.m. with Director of Nursing (DON), DON stated the wound nurse was available only on the weekend. DON stated licensed nurses were required to assess and provide care for the wound when the wound nurse was not available. DON stated wound assessments were required to be completed weekly either by the licensed nurses or the wound nurse. DON stated wound assessment were to monitor the change of condition of the wound; if the wound is getting worse or better. DON stated untreated wounds can lead to sepsis (blood poisoning) and death. DON stated wounds should be assessed (including measurements) when providing treatment and should be assessed at minimum of once a week. DON stated documentation of the assessments were required to be kept in the resident ' s medical record to monitor trend. DON stated the medical record must be complete and accurate to reflect the quality of care provided at the facility. During an interview on 7/11/23 at 3:23 p.m. with Administrator (ADM), ADM stated the reason for wound assessment were to see if the wound was getting better or worse. ADM stated wounds should be assessed at minimum weekly and during each treatment to see if the treatment is effective. ADM stated assessments were required to be in medical records to reflect care provided. ADM stated the resident ' s medical record must be complete and accurate in case family request a copy of the resident ' s medical record. ADM stated if wound care was completed and documented and the assessments (with measurements) were not documented it was not completed. During a review of the facility ' s policy and procedure (P&P) titled, Charting and Documentation, dated 7/2017, the P&P indicated, Policy Statement: All services provided to the resident, progress toward the care plan goals, or any changes in the resident ' s medical, physical, functional or psychosocial condition, shall be documented in the resident ' s medical record . Policy Interpretation and Implementation: .2. The following information is to be documented in the resident medical record: .c. Treatments or services performed . 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate . 7. Documentation of procedures and treatments will include care-specific details, including: .c. The assessment data and/or any unusual findings obtained during the procedure/treatment . During a review of the facility ' s P&P titled, Prevention of Pressure Injuries, dated 4/2020, the P&P indicated, Purpose: The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. Preparation: Review of the resident ' s care plan identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. Risk Assessment: 1. Assess the resident on admission (within eight hours) for existing pressure injury risk factors. Repeat the risk assessment weekly and upon any changes in condition . Skin Assessment: 1. Conduct a comprehensive skin assessment upon (or soon after) admission, with each risk assessment, as indicated according to the resident ' s risk factors, and prior to discharge .