STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055206	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plaza Healthcare Center	1209 Hemlock Way Santa Ana, CA 92707

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49780 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to promote the wound healing for two of two sampled residents (Residents 1 and 2). * The facility failed to ensure the physician's order for wound care was followed for Resident 1's Stage 4 pressure injury. * The facility failed to ensure Resident 1 who had a Stage 4 pressure injury to the sacral coccyx area was repositioned while in bed to promote the wound healing. * The facility failed to carry out the physician's wound care order written by the wound care physician for Resident 2's pressure u injury. These failures posed the risk for complications and delayed wound healing. Findings: Review of the facility's P&P titled Pressure Injury and Skin Integrity Treatment revised 8/12/16, showed the treatments to pressure injuries and other skin integrity problems will be provided as ordered by the physician. 1.a. Medical record review for Resident 1 was initiated on 7/30/24. Resident 1 was admitted to the facility on [DATE], with the diagnoses, including paraplegia, Stage 4 pressure injury of sacral coccyx, and Stage 4 pressure injury of left ischium. Review of Resident 1's Order Summary Report dated 7/30/24,showed the following physician's orders dated 7/22/24: - Coccyx wound: to cleanse with normal saline; pat dry; apply Santyl (an ointment used to remove damage tissue from chronic skin ulcers and severely burned areas); pack with the moistenedgauze, abdominal pad, and foam dressing; and apply triamcinolone (medication to manage and treat skin conditions associated with redness, itching, swelling, or other discomfort) 0.1% to wound bed for hypergranulation every day shift for 21 days (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Left ischium wound: to cleanse withnormal saline; pat dry; apply Santyl, pack with moistenedgauze and abdominal pad; cover with a foam dressing every day shift for 22 Days. On 7/30/24 at 1105 hours, a wound treatment observation for Resident 1 was conducted with LVN 7. LVN7 applied Medihoney (a paste that used to treat a variety of wounds including pressure ulcers) to the left ischium wound, packed with moistened gauze, and covered with a foamdressing. On 7/30/24 at 1200 hours, an interview and concurrent medical record review was conducted with LVN 7. LVN 7 verified he had used Medihoney for theleft ischium wound. LVN 7 also stated Santyl should have been applied for both coccyx and ischium wounds. b. Review of Resident 1's MDS Section C dated 7/27/24, showed Resident 1 had a BIMS score of 13 which meant his cognition was intact. Review of Resident 1's MDS Section GG dated 7/27/24, showed Resident 1 needed supervision for rolling from lying on back to left and right side. Review of Resident 1's plan of care revised 7/30/24, showed a care plan problem addressing multiple pressure injuries, coccyx pressure injury, right heel pressure injury, left ischium pressure injury, and right lower posterior pressure injury. The interventions include to educate the resident, family, and caregivers the causes of skin breakdown including transfer, positioning requirements, importance of taking care during ambulating, mobility, and frequent repositioning. On 7/30/24 at 1413 hours, an interview was conducted with Resident 1. Resident 1 stated he was not able to move his legs and needed help from the staff to turn from side to side; and nobody helped him turn. Multiple observations of Resident 1 conducted on 7/31/24, showed Resident 1 was in the same position as follows: - at 0620 hours, Resident 1 was observed sleeping, in a supine position. - at 0839 hours, Resident 1 was observed in bed, in a supine position. - at 0956 hours, Resident 1 was observed in bed, in a supine position. - at 1120 hours, Resident 1 was observed in bed, in a supine position. - at 1205 hours, Resident 1 was observed in bed, in a supine position. On 7/31/24 at 1410 hours, an interview was conducted with CNA 7. CNA 7 stated Resident 1 needed to be turned every two hours. Resident 1 could not move his legs and was not able to turn by himself. CNA 7 further stated Resident 1 needed someone to turn him to the side in bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/31/24 at 0643 hours, an interview and concurrent medical record review for Resident 1 was conducted with LVN 3. LVN 3 stated when a resident had a pressure ulcer, the resident needed to be repositioned every two hours. The licensednurses would obtain an order for repositioning every two hours and would inform the CNAs to do it. LVN 3 verified Resident 1 did not have any order for repositioning and stated he should have an order for repositioning every two hours. On 7/31/24 at 1515 hours, an interview was conducted with theDON. The DON stated when a resident had a pressure injury, the physician wouldorder a wound treatment and repositioning every two to four hours; and to add repositioning as an intervention in the care plan. The DON verified Resident 1 did not have an order for repositioning and he should have repositioning as an intervention in his care plan. 2. Medical record review for Resident 2 was initiated on 7/30/24. Resident 2 was admitted to the facility on [DATE], with diagnoses including pressure injury of the right shoulder and right hip. On 7/30/24 at 1206 hours, a wound treatment observation for Resident 2 was conducted with LVN 7. LVN 7 applied Medihoney to Resident 2's right shoulder wound, placed the moistened gauze into the wound, and covered with a dressing. Review of Resident 2's Order Summary Report for July 2024 showed the following physician's orders dated: - 7/5/24, to apply Medihoney Wound & Burn Dressing External Paste (Wound Dressings) to the right shoulder topically every day shift for wound. - 7/22/24, to apply Santyl External Ointment 250 unit/gm to the right buttock lower side topically every day shift for 21 days; and to cleanse with normal saline, pat dry, apply Santyl, pack with the moistened gauze, and cover with the abdominal pad and foam dressing Review of Resident 2's wound assessment dated [DATE], by the wound caredoctor showed the following treatment orders: - Right posterior shoulder: to cleanse wound with normal saline or sterile water; apply Santyl, nickel thick layer; and cover with the moist gauze and dressing everyday and as needed. - Right trochanter (hip): to cleanse wound with normal saline or sterile water; apply Santyl, nickel thick layer; and cover with the moist gauze and dressing everyday and as needed. However, the new treatment orders from the wound care doctor on 7/29/24, were not carried out. On 7/31/24 at 1515 hours, an interview was conducted with the DON. The DON stated the licensed nurses were supposed to carry out the new orders from the wound doctor and document in the progress notes.