STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055374	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Upland Rehabilitation and Care Center	1221 East Arrow Hwy Upland, CA 91786

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** 44262 Based on interview and record review, the facility failed to ensure proper care was provided to prevent a pressure ulcer/injury (injury to skin/tissue from prolonged pressure on the skin) for one of three sampled residents (Resident 1). This failure placed a clinically compromised Residents (Resident 1) health and safety at risk, when a facility acquired unstageable pressure ulcer to coccyx left buttocks (lower back/spine) developed while in the facility. Findings: During review of Residents 1's Admission Record (general demographics), the document indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included metabolic encephalopathy (problem in brain caused by chemical imbalance in blood), acute respiratory failure with hypoxia (not enough oxygen), tracheostomy (opening in trachea to help air and oxygen reach lungs), acute kidney failure (kidney cant filter waste from blood). During a concurrent interview and record review of Resident 1's Medical Record with the Director of Nursing (DON) reviewed and verified the following: 1. Admission Skin Integrity assessment dated [DATE], at 2249: Sacro coccyx- scar tissue to coccyx, Unstageable Tissue Depth (UTD) Right and Left heel blister, right hand open wound, neck trachea stoma (opening) and abdomen Gastrostomy stoma. 2. Braden Scale for Predicting Pressure Sore Risk dated May 15, 2024, at 2315, Score 7, High Risk. 3. Situation, Background, Assessment and Recommendation (SBAR) communication form dated May 28, 2024: Moisture Associated Skin Damage (MASD) to Bilateral Buttocks, Certified Nursing Assistant (CNA) reported to charge nurse and treatment nurse that she observed MASD to Bilateral buttocks, doctor and daughter notified . 4. Phone Order May 28, 2024, at 1739: Turn and Reposition Q 2 hours every 2 hours. Phone Order May 29, 2024, at 7:00: Order for Low Airloss mattress for skin management. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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	5. SBAR June 10, 2024, Unstageable to coccyx left buttocks. Since this started: WORSE, Skin evaluation: Pressure Ulcer- Unstageable pressure ulcer to coccyx (tailbone) to left buttocks, cleanse with Normal Saline pat dry apply Manuka Honey, Xeroform (gauze with petrolatum) and cover with foam dressing every day for 21 days. Primary doctor notified and daughter notified. 6. CAREPLAN: Focus: Has potential for pressure ulcer development related to disease process, history of ulcers, immobility Date initiated May 16, 2024, Goal: Will have intact skin, free of redness, blisters or discoloration by/through review date, Interventions: Administer treatments as ordered and monitor for effectiveness, Daily body checks, turn and reposition as tolerated . During an interview with the Treatment Nurse, Treatment Nurse 1 stated I remember Resident 1 had a full thickness scarring on admission. When asked, what caused the pressure ulcer? Treatment nurse stated, We were treating MASD, her comorbidities she was already fragile. We were getting the wound doctor to see this resident, but family transported her to the hospital .for a new or worsening wounds we call the wound consult, but her for her she was already gone. During an interview with the Director of Nursing (DON), DON stated When she came in, she had no open wounds, it was a scar, and we were treating it. After the wound developed the mattress was placed May 29, 2024. When she came here is was scar tissue, was not an open wound, we have put in place interventions treatment for the scar tissue, Registered Dietician with supplements. They do tent to sweat and her comorbidities and incontinent bowel and bladder .we are cleaning this resident every 2 hours and sooner making sure she was dry. During a review of the facility's policy and procedure titled, Skin Management revised [December 2019, the policy and procedure indicated: It is the policy of this facility that any resident who enters the facility without pressure ulcers will have appropriate preventive measures taken to ensure that the resident does not develop pressure ulcers, or that residents admitted with wounds will not develop signs and symptoms of infection, unless the resident's clinical condition makes the development unavoidable.