

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055409	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/04/2024
NAME OF PROVIDER OR SUPPLIER Community Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4070 Jurupa Avenue Riverside, CA 92506	

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 - 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** 48240</p> <p>Based on interview and record review, the facility failed to ensure facility policy and procedures were implemented to prevent and identify the development of a pressure injury (PI- bed sore) for one of two sampled residents (Resident 1), when an open area of the skin identified on Resident 1 ' s sacrum (a large, triangular bone at the base of the spine) on August 30, 2024, was not assessed and was not provided treatment.</p> <p>These failures resulted in Resident 1 developing a stage 3 PI (full -thickness tissue loss, exposing fat tissue) which was identified on September 13, 2024.</p> <p>Findings:</p> <p>On October 22, 23, and November 4, 2024, unannounced visits were conducted at the facility to investigate a complaint.</p> <p>A review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included paraplegia (inability to move the lower parts of the body), post-polio syndrome (a condition that causes gradual muscle weakness and muscle loss that can affect people who've had polio - polio a virus that causes paralysis), bullous pemphigoid (a rare skin condition that causes blisters on the skin) and dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life).</p> <p>A review of Resident 1 ' s care plan titled #16 CAA: PRESSURE INJURY/ULCER dated June 23, 2021, indicated The resident has potential/actual for pressure injury development/worsening r/t disease process . limited mobility, incontinence (no control of bowels and/or bladder), episodes of refusing showers, episodes of scratching/picking skin and episodes of refusing to have fingernails trimmed, refusal to get OOB (out of bed), prefers to be positioned in bed in high [NAME] ' s (head of the bed raised up to 90 degrees) while awake placing resident at risk for shearing (occurs when the skin moves in one direction while the tissue underneath moves in another) . The care plan goal dated November 1, 2021, with June 21, 2024, as the latest revision date, indicated . The resident will have intact skin, free of redness, blisters, or discoloration by/through review date .Target Date: December 10, 2024. The care plan interventions included .administer medications as ordered .educate the resident as to causes of skin breakdown; including transfer/ positioning requirements .encourage resident to shift weight in bed as necessary for pressure relief .monitor/document/ report PRN (as needed) any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size and stage .</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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1's History and Physical dated June 7, 2024, indicated she can make needs known but cannot make medical decisions.</p> <p>A review of Resident 1 ' s Braden Scale for Predicting Pressure Ulcer dated June 21, 2024, indicated she was a high risk for developing PI.</p> <p>On October 22, 2024, at 12:28 p.m., during an interview with Certified Nurse Assistant (CNA) 1, CNA 1 stated the residents' skin condition is monitored every day when their briefs are changed and during showers. CNA 1 stated new skin conditions are reported to the charge nurse. CNA 1 stated Resident 1 was a total care resident, required two-person-assist with most ADLs (activities of daily living), was incontinent, and often refused care. CNA 1 stated Resident 1 had a wound on her buttocks that looked and smelled very bad. CNA 1 stated she was not sure when Resident 1 developed the wound.</p> <p>On October 22, 2024, at 12:58 p.m., during an interview with Licensed Vocational Nurse (LVN) 1, LVN 1 stated the CNAs reported abnormal skin conditions to the licensed or the treatment nurses (TXN) and documented it on the shower sheets.</p> <p>On October 22, 2024, at 1:44 p.m., during an interview with TXN 1, TXN 1 stated residents are assessed for risks of developing skin conditions upon admission. TXN 1 stated the facility conducted skin sweeps where all residents are checked for their current skin condition. TXN 1 stated Resident 1 had a stage 3 PI identified on September 13, 2024. TXN 1 stated it did not make sense to her that Resident 1 ' s PI was at stage 3 when it was identified. TXN 1 stated there were different CNAs assigned to residents for each shift and someone should have noticed something.</p> <p>On October 23, 2024, at 1:09 p.m., during a concurrent interview and record review, the TXN 2 stated the following:</p> <ol style="list-style-type: none"> a. The facility conducts skin sweep weekly or biweekly depending on staff availability. b. The skin inspection (shower sheet) dated August 10 and August 30, 2024, indicated Resident 1's skin was not intact and skin problem was identified by the CNA on the buttocks area and sacral area, respectively. c. The physician's orders, progress notes, and Treatment Administration Record (TAR), for August 2024, did not have documentation reflecting the skin issues identified on August 10 and August 30, 2024. Also, the TAR did not reflect treatment was initiated. d. A skin sweep was conducted on September 13, 2024, when Resident 1's stage 3 PI on the sacrococcyx extending to the right buttock was discovered. <p>A review of Resident 1's weekly summaries indicated a weekly summary was not completed on August 31, 2024, to reflect the status of the skin issue on the sacral area identified on August 30, 2024, during skin inspection.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On October 23, 2024, at 4:16 p.m., during an interview and concurrent record review with the Director of Nursing (DON), the DON stated the CNAs checked residents ' skin when they change them and during showers. The DON stated the CNAs uses shower sheets to document any skin issues and they would verbally communicate with the LVNs. The DON stated when CNAs report skin issues, the charge nurse needs to look at the patient and verify the skin issue. The DON stated if the skin issue was verified, the charge nurse communicates with the TXN so that the TXN can re-evaluate the resident. The DON stated the TXNs conducted a skin sweep for all residents monthly to ensure that no skin issue was missed. The DON stated the TXN conducted weekly skin evaluation, and the charge nurses conducted weekly summary where the residents' skin is assessed as well. The DON verified that Resident 1 did not have a weekly summary for August 24 and 31, 2024. The DON stated the nurses should be conducting their weekly summaries to document a summary of the residents ' condition.</p> <p>On November 4, 2024, at 11:28 a.m., a concurrent interview with CNA 2 and record review of Resident 1 ' s Skin Inspection dated August 30, 2024, was conducted. CNA 2 stated it was her signature on the document and she identified Resident 1 had redness on her right arm and a small open wound on her sacral area. CNA 1 stated she reported her findings to the charge nurse and treatment nurse that same day (August 30, 2024).</p> <p>A review of the Skin Only Evaluation dated September 13, 2024, indicated Resident 1 was noted with a stage 3 (full-thickness loss of skin tissue that appears as a crater-like sore, with dark patches of skin around the edges) pressure injury on her Sacro coccyx (tail bone) extending to the right buttock after conducting a skin sweep (checks the entire body for any skin wounds, as well as wound prevention). The wound measured 5.5. cm (length) x 2.5 cm (width) x 0.2 cm (depth), the wound bed was 80% slough (yellow/white material on the wound bed) and 20% granulation tissue a new connective tissue that forms in a wound during the healing process) with minimal serous drainage (clear fluid that leaks out of wounds), peri (around) wound is erythematous (inflamed skin).</p> <p>A review of Resident 1's physician's order, dated September 14, 2024, indicated, .Wound type: Stage 3 PI Wound site: Sacro coccyx Cleanse with: NS (normal saline), Pat dry Apply Santyl (an ointment) and Collagen (helps with wound healing), cover with foam dressing every day shift for Wound Healing for 30 days .</p> <p>A review of Resident 1 ' s progress notes and TAR for September 2024, indicated no documented evidence Resident 1 received wound treatment until September 15, 2024.</p> <p>A review of Resident 1's (name of wound specialist) Progress Notes dated September 26, 2024, indicated the sacrococcyx PI was reclassified to stage 4 (full thickness skin and tissue loss that exposes muscle, and bone).</p> <p>On November 4, 2024, at 11:55 a.m., during interview with TXN 2, TXN 2 stated when residents are identified with a wound, she would contact the doctor, would contact the family, and would write a treatment order following the facility wound treatment protocol, the day the wound was identified. TXN 2 verified Resident 1 ' s wound treatment was ordered on September 14, 2024, however; the TAR indicated Resident 1 received sacrococcyx wound treatment on September 15, 2024. (Two days after the PI was discovered).</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On November 4, 2024, at 1:44 p.m., during an interview with Registered Nurse (RN) 1, who was the Minimum Data Set (MDS - an assessment tool) Coordinator, RN 1 stated the interventions for residents identified as at risk for developing a PI include repositioning, encourage the resident to get out of bed as tolerated, provide moisture barrier cream, peri care, and a pressure reducing mattress. RN 1 stated all residents in the facility are provided with a pressure reducing mattress. RN 1 stated interventions for residents who are moderate and high risk for developing PI would be the same for those who are at risk because once a resident is identified as at risk for developing a PI, they implement all interventions right away to prevent the development of a wound. RN 1 stated the CNAs do not document turning and repositioning of the residents. RN 1 stated CNAs are trained to reposition residents every two hours and it was part of their daily routine.</p> <p>On November 12, 2024, at 10:00 a.m., during a telephone interview with the Director of Staff Development (DSD), the DSD stated when licensed nurses signed the Skin Inspection sheet, they acknowledged the wound or any skin issues reported by the CNA, and they should get a treatment order from the physician.</p> <p>A review of the facility ' s policy and procedure titled Skin assessment dated [DATE], indicated .It is our policy to perform a full body skin assessment as part of our systemic approach to pressure injury prevention and management .A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, and weekly thereafter .Documentation of skin assessment .Include date and time of the assessment, your name, and position title .Document observations .type of wound describe wound .document if resident refused assessment and why .other information as indicated or appropriate .</p> <p>A review of the facility's policy and procedure, titled Pressure Injury Prevention and Management, dated December 19, 2022, indicated .the facility shall establish and utilize a systematic approach for pressure injury and prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of interventions; and modifying the interventions as appropriate licensed nurses will conduct a pressure injury risk assessment, using the Braden Scale for Predicting pressure Ulcer Risk, on all residents upon admission/re-admission, weekly time 3 (sic) more weeks, then quarterly or whenever the resident's condition changes significantly .licensed nurses will conduct a full body skin assessment at least weekly after admission/re-admission. Findings will be documented in the medical record .Nursing assistants will inspect skin during bath and will report any concerns to the resident's nurse immediately after the task .after completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions .basic routine care interventions could include, but are not limited to: redistribute pressure. minimize exposure to moisture and keep skin clean .provide appropriate pressure-redistributing, support surfaces .provide non-irritating surfaces; and . maintain or improve nutrition and hydration status, where feasible .</p>		