Printed: 03/01/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055459	A. Building B. Wing	12/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Vista Care Center	1440 S Euclid Avenue Anaheim, CA 92802

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 - Potential for minimal harm

Residents Affected - Some

Provide appropriate pressure ulcer care and prevent new ulcers from developing.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48882

Based on interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services were provided to prevent the development of new pressure ulcers and promote the healing of existing pressure injuries for one of three sampled residents (Resident 2).

* The facility failed to provide Resident 2 with an alternating pressure pad as recommended by the Wound Consultant. This failure posed the risk for worsening of the existing pressure injuries or development of new pressure injuries for this resident.

Finding:

Review of the facility's P&P titled Pressure Ulcers/Skin Breakdown-Clinical Protocol dated 4/2018, showed the physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.), and application of topical agents. During resident visits, the physician will evaluate and document the progress of wound healing-especially for those with complicated, extensive, or poorly-healing wounds. The physician will guide the care plan as appropriate, especially when wounds are not healing as anticipated or new wounds develop despite existing interventions.

Closed medical record review for Resident 2 was initiated on 12/19/24. Resident 2 was admitted to the facility on [DATE]; readmitted on [DATE], with the diagnosis of Type 2 Diabetes Mellitus; and discharged on [DATE].

Review of Resident 2's H&P examination dated 4/28/24,showed Resident 2 had no capacity to understand and make decisions.

Review of Resident 2's MDS dated [DATE], showed Resident 2 was at risk for developing the pressure ulcers/injuries and had diabetic foot ulcers.

Review of Resident 2's Wound Consultant's Progress Notes dated 7/23 and 8/20/24, showed Resident 2 had a right and left heel diabetic ulcer. The section for Recommendations showed to offload the heels on the pillows and apply the heel protectors and alternating pressure pad.

(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 - Potential for minimal harm Residents Affected - Some	Review of Resident 2's Wound Consultant's Progress Notes dated 9/17/24, showed Resident 2 had the left lateral medial heel and right heel diabetic ulcers, and left lateral lower leg arterial ulcer. Thesection for Recommendations showed to offload the heels on the pillows and apply the heel protectors and alternating pressure pad. Further review of Resident 2's medical record failed to show aphysician's order for the alternating pressure pad. Review of Resident 2's progress notes failed to show documentation Resident 2 had an alternating pressure pad as recommended by the Wound Consultant. On 12/23/24 at 1300 hours, an interview was conducted with the Central Supply Staff. The Central Supply Staff stated for the ordering of the special mattresses for the residents, the treatment nurse would inform him, and he would contact the mattress rental company. On 12/23/24 at 1315 hours, an interview and concurrent closed medical record review for Resident 2 was conducted with LVN 1. LVN 1 stated she conducted weekly wound rounds with the Wound Consultant. LVN 1 stated she was responsible for reviewing the Wound Consultant's weekly progress notes to ensure the recommendations were followed. LVN 1 reviewed the above Wound Consultant's Progress Notes and acknowledged there were recommendations to provide Resident 2 with an alternating pressure pad. However, the facility did not have the alternating pressure pads. LVN 1 was asked if she had clarified the recommendation with the Wound Consultant. LVN 1 stated she did not and that she should have. When asked if the resident was on any special mattress, LVN 1 verified there was no order for any special mattress for the Resident 2. On 12/23/24 at 1330 hours, a follow-up interview was conducted with the Central Supply Staff. The Central Supply Staff stated he contacted the mattress rental company and verified there were no records of any special mattress ordered for Resident 2. On 12/23/24 at 1650 hours, a telephone interview was conducted with the Wound Consultant. The Wound Consult stated he expected the recommendations on his progress notes to be carried out. The Wound Consult stated if the facility did not have the recommended mattress, he expected the facility to inform him or to clarify the recommendation for an alternative mattress. On 12/23/24 at 1715 hours, the DON was informed and acknowledged the above findings.

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to maintain the highest physical well-being for one of five sampled residents (Resident 5). * The facility failed to provide the wound care treatments for Resident 5's left foot wounds as ordered by the physician. This failure had the potential for Resident 5 to not receive the appropriate care and services to treat his left foot wounds. Finding: Review of the facility's P&P titled Pressure Ulcers/Skin Breakdown- Clinical Protocol dated 4/2018 showed the physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.), and application of topical agents. Medical record review for Resident 5 was initiated on 12/19/24. Resident 5 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 5's H&P examination dated 7/22/24, showed Resident 5 had no capacity to understand and make decisions and had a diagnosis of Type 2 Diabetes Mellitus with other diabetic kidney complications. Review of Resident 5's Plan of Care showed the care plan problems initiated on 10/13/24, addressing the following: - Resident 5's altered skin integrity for the left 5th metatarsal. The interventions included to administer the treatment as ordered. - Resident 5's altered skin integrity for the left mid lateral foot. The interventions included to administer the treatment as ordered. Review of Resident 5's TAR for December 2024 showed a physician's order dated 12/18/24, for the following: - for the left mid to lateral foot diabetic ulcer, to cleanse with normal saline, pat dry, apply Betadine external solution 10% topically (antiseptic solution), apply an ABD pad (a highly absorbent sterile dressing), wrap with a kerlix roll of gauze, and secure with tape, every day during the day shifts for 14 days. - for the left 5th metatarsal head diabetic ulcer, to cleanse with normal saline, pat dry, apply Betadine external solution 10% topically, apply an ABD pad, wrap with a kerlix roll or gauze, and secure with tape every day during the day shifts for 14 days. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/23/24 at 1015 hours, a wound care observation for Resident 5 was conducted with LVN 1. LVN 1 was observed cleansing Resident 5's left foot wounds with the Gentell wound cleanser spray (a no rinse wound cleanser) and a gauze. On 12/23/24 at 1040 hours, a concurrent interview and medical record review for Resident 5 was conducted with LVN 1. LVN 1 reviewed Resident 2's treatment orders for the left foot and stated the physician's order was to cleanse Resident 5's left foot diabetic wounds with normal saline. When asked about the wound cleansers, LVN 1 stated the normal saline and Gentellwound cleanser were not the same. LVN 1 verified she used the Gentell dermal wound cleanser to cleanse Resident 5's left foot wounds. LVN 1 further stated the wound treatments should be administered to the residents as ordered by the physician. On 12/23/24 at 1338 hours, an interview as conducted with the DON. The DON stated the licensed nurses were expected to administer the wound treatments as ordered by the physician, to accurately reflect the resident's care. The DON further stated the Gentell wound cleanser and normal saline were not the same, and if the treatment nurse was using something other than what was ordered, the nurse should clarify the order with the physician. On 12/23/24 at 1715 hours, the DON was informed and acknowledged the above findings.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of three sampled residents (Resident 3) remained free from the accident hazards. * The facility failed to implement the bilateral floor mats as per the physician's order and plan of care for Resident 3 who was a high risk for falls and had a history of falls with injuries. This failure had the potential to place Resident 3 at risk for serious injury. Findings: Review of the facility's P&P titled Falls and Fall Risk, Managing revised 3/2018 showed the staff member, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. Medical record review for Resident 3 was initiated on 12/23/24. Resident 3 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 3's H&P examination dated 9/13/24, showed Resident 3 was confused but was able to make her needs known. Review of Resident 3's Post-Fall Review dated 9/7/24, showed on 9/7/24 at 1000 hours, Resident 3 had a fall in her room. The form showed Resident 3 was found sitting on the floor next to her bed with swelling on her left cheek, purplish discoloration on her left eye and left shoulder, and a left-hand skin tear. Review of Resident 3's Order Summary Report dated 12/23/24, showed a physician's order dated 9/12/24, to implement the bilateral floor mats while the resident was in bed for fall management. Review of Resident 3's Plan of Care showed a care plan problem dated 9/12/24, addressing Resident 3's high risk for falls and injuries. The interventions included to implement bilateral floor mats as ordered and to apply bilateral floor mats while in bed for fall management. On 12/23/24 at 1010 and 1109 hours, Resident 3 was observed lying in bed with the floor mat on the left side of the bed. A floor mat was not observed on the right side of Resident 3's bed. On 12/23/24 at 1110 hours, a concurrent observation and interview was conducted with CNA 2. CNA 2 stated Resident 3 was a fall risk and had a fall in the past. CNA 2 verified Resident 3 only had a floor mat on the left side of the bed. CNA 2 stated Resident 3 had attempted to get out of bed unassisted in the past and there was a potential risk that Resident 3 would attempt to get out of bed on the right side. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/23/24 at 1115 hours, an observation, interview, and concurrent medicalrecord review for Resident 3 was conducted with the DSD. The DSD verified the above findings. The DSD stated the resident should have the bilateral floor mats as ordered by the physician. The DSD further stated the purpose of the floor mats wasto mitigate any injuries in the event the resident had a fall. On 12/23/24 at 1338 hours, an interview and concurrent medical record review for Resident 3 was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the appropriate pain management was provided for one of three sampled residents (Resident 2). * The facility failed to ensure Resident 2 was consistently provided the non-pharmacological pain interventions prior to the administration of acetaminophen (analgesic) medication. This failure had the potential to put Resident 2 at risk for ineffective pain management and adverse effects related to the use of unnecessary pain medication. Finding: Review of the facility's P&P titled Pain Assessment and Management revised 10/2022 showed the non-pharmacological interventions may be appropriate alone or in conjunction with medications. Pharmacologic interventions (i.e. analgesic) may be prescribed to manage pain, however they do not usually address the cause of pain and can have adverse effects on the resident (e.g. drowsiness, increased risk of falling; loss of appetite). Closed medical record review for Resident 2 was initiated on 12/19/24. Resident 2 was admitted to the facility on [DATE], readmitted on [DATE], and discharged on [DATE]. Review of Resident 2's H&P examination dated 4/28/24, showed Resident 2 had no capacity to understand and make decisions. Review of Resident 2's Order Summary Report dated 12/23/24, showed the following physician's orders dated 4/26/24: - to monitor for the highest pain level from the pain scale level of 0-10 (0 = no pain and 10 = worst pain) every shift, - for the non-pharmacological pain interventions: to record any non-drug intervention used to prevent or relieve pain, which were coded as follows: 0 - No Non-Drug Interventions Needed 1 - Music/Radio 2 - 1:1 Conversation/Listening 3 - Repositioned for comfort 4 - Activity/Exercise/Stretch 5 - Rest Period/Sleep 6 - Verbal cues/Prompting/Reassuring (continued on next page)

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7 - Redirection/Refocus/Diversion 8 - Deep Breathing/Relaxation 9 - Remove from Stimuli/Problem solving 10 - Other, as needed - to administer acetaminophen 325 mg two tablets by mouth every six hours as needed for mild pain (pain levels of 1-3) to moderate pain (pain levels of 4-6) Review of Resident 2's Plan of Care showed a care plan problem dated 4/26/24, addressing Resident 2's alteration in comfort. The interventions included to documentany non-drug interventions used to prevent or relieve pain. Review of Resident 2's MAR for September 2024 showed Resident 2 was administered acetaminophen 325 mg two tablets as needed for pain on the following dates: 9/9, 9/13, 9/19, 9/20, 9/21, 9/22, and 9/23/24. However, the MAR failed to show documented evidence the non-pharmacological pain interventions were providedon 9/9, 9/13, 9/20, 9/22, and 9/23/24, prior to the administration of the pain medication. On 12/23/24 at 1338 hours, an interview and concurrent closed medical record review for Resident 2 was conducted with the DON. The DON verified the above findings. The DON stated prior to the administration of the pain medications, the nurses were expected to attempt and document the non-pharmacologic pain interventions provided to the residents. On 12/23/24 at 1715 hours, the DON was informed and acknowledged the above findings.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the medical record for one of five sampled resident (Resident 2) was complete and accurate. * The facility failed to ensure the attempts to obtain and schedule a vascular consult for Resident 2 were documented. This failure had the potential for the resident's care needs not being met as their medical information was incomplete and inaccurate. Findings: Review of the facility's P&P titled Charting and Documentation revised 7/2017 showed all services provided to the resident, the 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. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The following information is to be documented in the resident's medical record: a. Objective observations; b. Medications administered; c. Treatments or services performed; d. Changes in the resident's condition; e. Events, incidents, or accidents involving the resident; and f. Progress toward or changes in the care plan goals and objectives. Closed medical record review for Resident 2 was initiated on 12/19/24. Resident 2 was admitted to the facility on [DATE]; readmitted on [DATE], with a diagnosis of Type 2 Diabetes Mellitus; and discharged on [DATE]. Review of Resident 2's H&P examination dated 4/28/24, showed Resident 2 had capacity to understand and make decisions. Review of Resident 2's Order Summary Report dated 12/23/24, showed a physician's order dated 9/10/24, for a vascular consultation. Review of Resident 2's closed medical record failed to show documentation Resident 2 was seen and evaluated by a vascular consultant. Review of Resident 2's Progress Notes failed to show documentation the physician's order for a vascular consult was carried out. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	On 12/23/24 at 1615 hours, an interview was conducted with the Medical Record Director. The Medical Record Director stated the nurses were responsible for carrying out the physician's order for the vascular consult. On 12/23/24 at 1625 hours, an interview and concurrent record review was conducted with the DON. The DON stated at the time RN 1 received the physician's order, RN 1 was responsible for carrying out the order for the vascular consult. The DON was asked to show the documentation if RN 1 had attempted to find a vascular consultation for Resident 2. The DON stated she was unable to find the documentation. On 12/23/24 at 1645 hours, a telephone interview was conducted with RN 1. RN 1 stated she received the physician's order for the vascular consult for Resident 2. RN 1 stated she attempted to schedule a vascular consult for Resident 2; however, the earliest appointment was two to three months from that time. RN 1 stated she had informed Nurse Practitioner 1 and was instructed to continue to find a vascular surgeon who could see the resident as soon as possible. When asked if RN 1 documented when she informed Nurse Practitioner 1, RN 1 stated she did not document in Resident 2's medical record her attempts to schedule a vascular consult and/or her notification to Nurse Practitioner 1. On 12/23/24 at 1715 hours, the DON was informed and acknowledged the above findings.