STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055570	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Elizabeth Healthcare Center	2800 N. Harbor Blvd. Fullerton, CA 92835

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** 47476 Based on interview, medical record review, and facility document review, the facility failed to ensure one of two sampled residents (Resident 1) was provided with the necessary care and services to prevent the development and worsening of pressure injuries. * Resident 1 was evaluated to have a Stage 1 pressure injury to his sacral coccyx on 1/3/24. Resident 1's sacral coccyx pressure injury had advanced to a Stage 2 pressure injury on 1/11/24. On 1/17/24, Resident 1's wound was evaluated by Wound Specialist 1 as an unstageable pressure injury. The facility failed to ensure Resident 1's sacral coccyx unstageable pressure injury was continued to be treated by Wound Specialist 1. This failure posed the risk for Resident 1's pressure injury to deteriorate and develop additional pressure injuries. Findings: Review of the facility's P&P titled Skin and Wound Monitoring and Management revised 12/2023 showed it is the policy of the facility that a resident having a pressure injury receives the necessary treatment and services to promote healing, prevent infection, and prevent new, avoidable pressure injuries from developing. Medical record review for Resident 1 was initiated on 5/6/24. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's MDS dated [DATE], showed Resident 1 required substantial to maximal assistance to roll left and right in bed. The MDS further showed Resident 1 was at risk for developing pressure injuries and did not have any pressure injuries on admission to the facility. Review of Resident 1's Skin Pressure Ulcer Weekly dated 1/3/24,showed Resident 1 developed a sacral coccyx Stage 1 pressure injury with non-blanchable redness, measuring 6.2 cm (length) x 6.0 cm (width). Review of Resident 1's Skin Pressure Ulcer Weekly dated 1/11/24,showed Resident 1 developed a Stage 2 pressure injury on the sacral coccyx area, measuring 6.0 cm (length) x 6.0 cm (width) x 0.1 cm (depth). Review of Resident 1's Order Summary Report dated 1/31/24, showed a physician's order for a wound care consult dated 1/13/24. (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	Review of Resident 1's Wound Specialist evaluation dated 1/17/24, showed Wound Specialist 1 was asked by the physician to evaluate and treat Resident 1's multiple wounds. The evaluation showed Resident 1 had a sacral coccyx unstageable pressure-induced tissue damage, measuring 6.2 cm x 8.2 cm after debridement of the wound. The wound tissue type showed 30% granulation, 20% slough, 20% eschar, and 30% purple tissue. The evaluation showed Wound Specialist 1 would be visiting Resident 1 on a weekly basis and as needed until all the wounds healed or otherwise specified. Further review of Resident 1's medical record failed to show documented evidence Wound Specialist 1 re-evaluated Resident 1's pressure injury after the initial visit on 1/17/24, or specified why Resident 1 had no longer required the services from the wound care specialist. Review of Resident 1's Skin Pressure Ulcer Weekly dated 2/24/24,showed Resident 1 had a sacral coccyx unstageable pressure injury, measuring 6.1 cm x 6.0 cm. The description of the wound showed 30% granulation, 20% slough, 20% eschar, and 30% purple discoloration. Review of Resident 1's Discharge Summary and Post-Discharge Plan of Care dated 3/1/24, showed Resident 1 required ongoing wound treatment for his sacral coccyx unstageable pressure injury. Review of Resident 1's MDS discharge date d 3/2/24,showed Resident 1 had one unhealed unstageable pressure injury upon discharge from the facility. On 5/7/24 at 1023 hours, a concurrent interview and medical record review was conducted with the DSD/IP regarding the development and evaluation of Resident 1's sacral coccyx unstageable pressure injury. The DSD/IP stated the wound care specialist would come once a week and was ordered for Resident 1 on 1/13/24. The DSD/IP stated once the wound care specialist saw the resident, they would make a note if they were followed. The DSD/IP was informed of the wound care specialist's consultation on 1/17/24 and was informed there was no documented evidence of the follow-up visits from Wound Specialist 1. The DSD/IP stated she would follow up if there were more progress notes from Wound Specialist 1. On 5/7/24 at 1300 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated there was only one initial visit note from Wound Specialist 1 and was not sure why Wound Specialist 1 did not follow up regarding Resident 1's wound. On 5/7/24 at 1333 hours, a telephone interview was conducted with the Wound Specialist Manager. The Wound Specialist Manager verified Resident 1 only had one initial wound consultation visit with Wound Specialist 1. The Wound Specialist Manager stated there were no notes or documentation on other visits for Resident 1 and no documentation available as to why Resident 1 was not continued to be seen by Wound Specialist 1. The Wound Specialist Manager stated Wound Specialist 1 was on vacation and could not follow up until he returned. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/24 at 1425 hours, a follow-up interview and concurrent medical record review was conducted with the DON. The DON stated the wound care specialist would directly schedule their visits with the wound care nurse. The DON verified there was only one initial consultation visit for Resident 1 from Wound Specialist 1, and no follow-up visits were made. The DON stated if the wound care specialist's visits were not needed weekly, the wound care specialist would let them know. The DON verified there was no communication to the facility regarding if Resident 1's wound care specialist's visits were changed or discontinued. The DON acknowledged the above findings and stated she would need to work with the wound care specialist.