

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055653	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2024
NAME OF PROVIDER OR SUPPLIER South Coast Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1030 W Warner Ave 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)
<p>F 0686</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>48853</p> <p>Based on observation, interview, and medical record review, the facility failed to ensure the necessary care and services were provided to prevent the development or worsening of pressure injuries for one of two sampled residents (Resident 8).</p> <p>*Resident 8 developed a Stage 4 pressure injury to the right buttock after admission to the facility. The facility failed to provide the skin treatment to Resident 8's right buttock as ordered by the physician. This failure had the potential for Resident 8 to not receive the appropriate care and services to promote healing of the pressure ulcer.</p> <p>Findings:</p> <p>Review of Resident 8's Order Summary Report dated 6/7/24, showed a physician's order dated 6/6/24, for Santyl external ointment 250 unit/gm (collagenase, a prescription medicine which removes dead tissue from wounds so they can start to heal), apply to the right buttock, cleanse with NS, pat dry, apply and pack lightly with a xeroform gauze, and cover with a dry dressing topically every day shift for the pressure injury wound for 30 days.</p> <p>On 6/7/24 at 0920 hours, a wound care observation for Resident 8's right buttock pressure ulcer was conducted with LVN 2. LVN 2 cleaned the right buttock pressure injury with NS, applied Santyl external ointment, and covered with a dry dressing.</p> <p>On 6/7/24 at 1034 hours, an interview was conducted with LVN 2. LVN 2 verified he did not pack Resident 8's right buttock pressure injury with the xeroform gauze.</p> <p>On 6/20/24 at 1545 hours, an interview was conducted with the DON. The DON stated wound care should be done as ordered by the physician. The DON was informed and acknowledged the above findings.</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 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of two sampled residents (Resident 8) maintained the acceptable parameters of nutritional status.</p> <p>* The facility failed to ensure the IDT evaluated and monitored the effectiveness of the intervention implemented after 3/13/24, for Resident 8's unplanned severe weight loss. This failure had the potential for Resident 8's compromised nutritional status was not monitored effectively which could lead to further medical complications.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Weight Management dated 8/25/21, showed in the event of a patterned or significant, unplanned weight loss/gain of at least 2% in a week (or +/- 3lbs), 5% in 30 days (or +/- 5lbs), 7.5% in 90 days or 10% in 180 days, the IDT collaborates for determining the need for initiation r discontinuation of weights other than weekly or as ordered by physician; and to request lab work as necessary.</p> <p>Medical record review for Resident 8 was initiated on 6/7/24. Resident 8 was admitted to the facility on [DATE], with diagnoses including pressure injury.</p> <p>Review of Resident 8's weight record showed the ideal body weight of 142 lbs and the following monthly weights:</p> <ul style="list-style-type: none"> - 1/1/24 at 1356 hours, 115 lbs - 2/1/24 at 0951 hours, 111 lbs, a loss of 4 lbs from the previous month - 3/1/24 at 1314 hours, 97 lbs, a loss of 14 lbs from the previous month - 4/2/24 at 1554 hours, 89 lbs, a loss of 8 lbs from the previous month - 5/1/24 at 1942 hours, 88 lbs, a loss of 1 lb from the previous month - 6/3/24 at 1739 hours, 91 lbs, a gain of 3 lbs from the previous month <p>Review of Resident 8's Data Collection and Nutritional Assessment Form dated 3/13/24, showed the resident's weight was 97 lbs. with a BMI of 15.7. Resident 8 had a 13% weight loss from February to March 2024 and a 16% weight loss from January to March 2024. The interventions included to monitor the laboratory tests for changes.</p> <p>Review of Resident 8's IDT Weight assessment dated [DATE], showed the IDT agreed with the RD's recommendation to continue to monitor the laboratory tests for changes and monitor the weights.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 8's care plan for nutrition initiated 1/8/21, and last revised 3/17/24, showed the interventions included to obtain the laboratory tests and weigh the resident as ordered.</p> <p>Review of Resident 8's Dietician Progress Notes dated 4/19/24, showed the resident's weight of 89 lbs was noted on 4/2/24, a decrease of 8 lbs or 8.25% in one month, significant and unplanned, weight loss trend in 6 months. No new laboratory tests to assess.</p> <p>Review of Resident 8's laboratory reports showed no documented evidence of any laboratory work completed from March to April 2024.</p> <p>Review of Resident 8's Order Summary Report from March 2024 to April 2024 failed to show any laboratory work was ordered between March to April 2024.</p> <p>Further review of the medical record showed no documented evidence the licensed nurse had followed up with the physician regarding the laboratory test order as per the IDT recommendation on 3/13/24, and the resident's care plan.</p> <p>On 6/20/24 at 0825 hours, Resident 8 was observed eating in the resident's room. Resident 8 was dependent on the staff with eating. CNA 4 was observed feeding the resident who consumed 50% of the breakfast tray.</p> <p>On 6/20/24 at 1600 hours, a concurrent interview and medical record review was conducted with the RD. The RD verified Resident 8's significant and progressive weight loss over the past four months and confirmed there was no laboratory work ordered or completed from March to April 2024.</p> <p>On 6/21/24 at 1030 hours, a concurrent interview and medical record review was conducted with the DON. The DON verified Resident 8's significant and progressive weight loss over the past four months and confirmed there was no laboratory work ordered or completed from March to April 2024. The DON verified there were no further IDT meetings for weight loss conducted after March 2024.</p> <p>On 6/25/24 at 0800 hours, Resident 8 was observed eating in the resident's room. Resident 8 was dependent on the staff with eating. LVN 4 was observed feeding Resident 8 who consumed 70% of the breakfast tray.</p> <p>On 6/26/24 at 1630 hours, the DON and Administrator were informed and acknowledged the above findings.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>48853</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to establish and maintain the infection control program and practices designed to help prevent the development and transmission of diseases and infections as evidenced by:</p> <ul style="list-style-type: none"> * The facility failed to ensure the EBPs were followed for Resident 8 when the staff did not wear a disposable gown before providing care to the resident. * The facility failed to ensure the hand hygiene was performed after using the gloves in between the dressing change. <p>These failures had the potential for spread of infections in the facility.</p> <p>Findings:</p> <p>Review of facility's P&P titled Enhanced Standard/Barrier Precautions (undated) showed Enhanced Standard/Barrier Precautions refer to the use of gown and gloves for use during high contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). Wear gowns and gloves while performing the following tasks associated with the greatest risk for MDRO contamination of hands, clothes, and the environment:</p> <ul style="list-style-type: none"> i. Morning and evening care ii. Device care, for example, central line, urinary catheter, feeding tube, tracheostomy, vascular catheter, ventilator tubes, iii. Any care activity where close contact with the resident is expected to occur such as bathing, peri-care, providing assistance with personal hygiene, assisting with toileting, changing incontinence briefs, respiratory care, wound care, etc. iv. Transferring v. Changing bed linens vi. Any care activity involving contact with environmental surfaces likely contaminated by the resident vii. In multi-bedrooms, consider each bed space as a separate room and change gowns and gloves and perform hand hygiene when moving from contact with one resident to contact with another resident <p>Review of Resident 8's Order Summary Report date 6/7/24, showed an order for Enhanced Standard Precaution dated 4/1/24.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. On 6/7/24 at 0905 hours, there was an Enhanced Standard Precautions sign posted outside of Resident 8's door alerting anyone entering the room to perform hand hygiene and don the gowns and gloves participating in any of the six moments of care:</p> <ul style="list-style-type: none"> - Morning and evening care, - Toileting and changing of incontinent briefs - Caring of devices and giving medical treatments - Cleaning and disinfecting the environment - Wound care - Mobility assistance and preparing to leave the room <p>a. On 6/7/24 at 0905 hours, LVN 2 and Resident 8's RP were in the resident's room. LVN 2 and Resident 8's RP were not wearing a disposable gown. LVN 2 removed the diabetic ulcer dressing with a gloved hand. LVN 2 was observed starting to perform wound care without wearing a disposable gown.</p> <p>On 06/7/24 at 0908 hours, an interview was conducted with LVN 2. LVN 2 stated he thought the gown was worn only for those residents who had tubes or catheters.</p> <p>b. On 6/25/24 at 0800 hours, LVN 4 was observed feeding Resident 8 in the resident's room. LVN 4 was not wearing a disposable gown and was sitting beside the resident's bed.</p> <p>On 6/26/24 at 1030 hours, an interview was conducted with the IP. The IP was informed and acknowledged the above findings. The IP stated LVN 4 should wear gown during feeding the resident in the resident's room.</p> <p>2. On 6/7/24 at 0909 hours, a wound care observation for Resident 8's right foot was conducted with LVN 2. LVN 2 changed gloves twice without washing hands in between while cleaning the resident's wound with NS.</p> <p>On 6/7/24 at 0920 hours, a subsequent wound care observation for Resident 8's right buttock pressure injury was conducted with LVN 2. LVN 2 rolled the resident's diaper down and removed the old dressing from the right buttock. LVN 2 cleaned the right buttock pressure injury with NS and changed the gloves without washing hands for three times.</p> <p>On 6/7/24 at 0937 hours, an interview was conducted with LVN 2. LVN 2 verified the failure to perform hand hygiene between changing the gloves during the above observations.</p> <p>On 6/7/24 at 1041 hours, an interview was conducted with the facility's IP. The IP was informed and acknowledged the above findings.</p>