STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055885	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Drive Post Acute	2500 Country Drive Fremont, CA 94536

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 - 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** Based on interview and record review, the facility failed to ensure for one out of three sampled residents (Resident 1), monitoring and interventions were in place to prevent development of pressure ulcer (skin and soft tissue injuries that develop due to prolonged pressure exerted over specific areas of the body). Resident 1 developed a pressure ulcer on posterior of the right lower leg where an immobilizer (a device used to support and stabilize the leg and knee) was applied. These failures resulted in a facility acquired, unstageable pressure ulcer (pressure ulcer known but not stageable due to coverage of wound bed by moist dead tissue and/or crusty, dry, and dead tissue), on the right lower leg that caused pain and extended Resident 1 ' s stay at the facility. Findings: During a review of facility ' s admission Record (AR) printed on [DATE], the AR indicated Resident 1 was admitted on [DATE], with diagnoses that included Periprosthetic Fracture Around Internal Prosthetic Right Hip Joint, (A broken bone around a hip replacement). Resident 1 ' s physician Order Recap Report for [DATE] indicated, right leg-knee immobilizer at all times, and non-weight bearing tight [right] leg. Resident 1 ' s Braden Scale for Predicting Pressure Sore Risk, (an assessment tool used evaluate a risk for developing pressure ulcer) dated [DATE] indicated a score of 13 (Moderate risk score 13 - 14). Resident 1 ' s Body Check dated [DATE], indicated there were no identified skin problem on Resident 1 ' s right leg. During a review of Resident 1 ' s clinical record titled Care Plan Report (CPR), initiated on [DATE], indicated Resident 1 Has higher risk of/potential for pressure ulcer development r/t [related to] Disease process. Planned interventions in the CPR included Assess/record/monitor wound healing (FREQ) [Frequency]. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress . Follow facility policies/protocols for the prevention/treatment of skin breakdown. Resident 1 ' s CPR did not identify and include interventions for Resident 1 ' s risk of skin breakdown on the right leg from the use of immobilizer. Resident 1 ' s CPR did not indicate a refusal of care for skin check underneath the right leg immobilizer. Further, Resident 1 ' s CPR was not updated when a pressure ulcer was identified on [DATE]. During a review of Resident 1 ' s Minimum Data Set (MDS - resident assessment tool) dated [DATE], the MDS indicated a Brief Interview for Mental Status (BIMS, a scoring system used to determine the resident ' s cognitive status regarding attention, orientation, and ability to register and recall information) score of 10, (BIMS score of 08 - 12, moderate cognitive impairment). Resident 1 ' s MDS skin assessment, indicated Resident 1 was at risk developing pressure ulcers/injuries, and had no unhealed pressure ulcer/injuries. (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 - Actual harm Residents Affected - Few	During a review of Resident 1 ' s clinical record titled Change in Condition Evaluation - V5.1 (CICE) dated [DATE], the CICE indicated, Resident 1 was identified to have Skin wound or ulcer. The CICE indicated, Resident has c/o [complaint of] pain and discomfort. The CICE indicated Resident 1 ' s skin changes were in Site 43. Right lower leg (rear), and Description: wound and redness on R [right] -leg (rear). Resident 1 ' s skin wound or ulcer was not measured in length, width, and depth, and there was no description of the underlying tissue of the wound. During a review of Resident 1 ' s Physician Progress Notes (PPN) dated [DATE], indicated Staff reported wound on rt [right] leg at lower end of knee immobilizer . Plan- hold d/c [discharge] until wound healing . Visit Diagnoses Primary: Pressure Ulcer, Unspecified site and stage. During an interview on [DATE] at 2:22 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated when Resident 1 ' s pressure ulcer was discovered on [DATE], there was no wound measurement done. LVN 1 stated Resident 1 ' s physician was visiting the facility, and they took a picture of the wound. LVN 1 stated that on [DATE], physician ordered a treatment with Medi honey with calcium alginate (dressing used for moderate to heavy oozing wounds and to cover a shallow or fill a deep wound) indicating the pressure ulcer had slough (dead tissue usually yellow, tan, gray, or green in color, usually moist and stingy in texture). During a concurrent interview and record review on [DATE] at 9:49 a.m., with Director of Nursing (DON), DON stated Resident 1 was admitted with right leg immobilizer. DON reviewed Resident 1 ' s clinical record for skin monitoring on the right leg underneath the immobilizer. DON was unable to show that Resident 1 ' s right leg skin underneath the immobilizer was being checked. DON stated the Resident 1 ' s skin should have been checked at least once every shift. During an interview on [DATE] at 12:35 p.m., with Registered Nurse (RN) 1, RN 1 stated if Resident 1 ' s skin was checked underneath the immobilizer, it would be documented in the treatment administration record (TAR). During a concurrent interview and record review on [DATE] at 10:21 a.m., with DON, DON provided Resident 1 ' s Order Recap Report for the month of [DATE]. DON stated there was an order to check to check the skin on Resident 1 ' s right leg. The physicians order dated [DATE], indicated monitor the skin under brace to right leg daily, notify MD [Medical Doctor] if any changes of condition. every day shift. During a concurrent interview and record review on [DATE] at 12:50 p.m., with DON, DON presented Resident 1 ' s Skin Monitoring Comprehensive CNA Shower Review for the following dates [DATE], [DATE], and [DATE]. DON stated after the CNA provided Resident 1 ' s bed bath, CNA would provide the forms to the licensed nurse to sign acknowledging it with a counter signature. The skin monitoring form shower review forms revealed Resident 1 ' s skin underneath the immobilizer on the right leg were not checked. During an interview on [DATE] at 12:18 p.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated only the licensed nurses would check the resident ' s skin under the immobilizer. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 ' s clinical record titled Interdisciplinary Care Conference - V 5 (IDCC) dated [DATE], IDCC indicated a Care Conference for Skin Alteration, for a Trauma - device acquired injury, located at Resident 1 ' s right shin, the measurement for length, width, and depth were blank, and the comment indicated IHA, (In house acquired). The ordered treatment was right lower shin posterior device related pressure injury: cleanse with NS, pat dry apply iodosorb cream and cover with border foam dressing daily, (NS - normal saline; Iodosord - medication used treat wet pressure ulcers and wounds). During a concurrent interview and record review on [DATE] at 10:40 a.m., with DON, DON reviewed Resident 1 ' s Interdisciplinary Care Conference - V 5 (IDCC) dated [DATE], IDCC indicated a Care Conference for Skin Alteration, a wound type was Trauma - device acquired injury, located at Resident 1 ' s right shin, with length in centimeter (cm) 10 cm, width 3 cm, and depth was left blank, and a comment indicated IHA. DON stated Resident 1 ' s pressure ulcer measurement was done on [DATE], and there was no measurement done when pressure ulcer was identified on [DATE]. DON stated the pressure ulcer was IHA. During a review of Resident 1 ' s clinical record dated [DATE], the Physician Progress Notes (PPN), indicated Add cefadroxil bid [two times a day] for 1wk [week] for possible cellulitis (bacterial skin infection) around wound-no fever, ., (Cefadroxil - mediation used to treat bacterial infection). Primary visit diagnoses: Pressure ulcer, unspecified site and stage. Resident 1 ' s PPN dated [DATE] indicated D/w [Discussed with] wound nurse, pt [patient] may need surgical debridement (medical procedure to remove the dead or infected tissue), by surgeon or ortho [orthopedic doctor] given proximity to tendon. Dtr [Daughter] was notified that wound healing may take few wks [weeks]. Resident 1 ' s PPN dated [DATE], indicated, Had lengthy discussion with dtr [Daughter] last week, dtr [Daughter] was concerned about avoidable decub [decubitus/pressure ulcer], pt ' s [patient ' s] lack of socialization and motivation etc, worry if pt [patient] giving up. Size of decub [decubitus/pressure ulcer] getting smaller, slough getting softer too. During a review of Resident 1 ' s clinical record titled Skilled Nursing Facility Discharge Summary SNFDS dated [DATE], SNFDS indicated Resident 1 ' s Date of Discharge was [DATE] with diagnoses that included rt [Right] femur fracture, and rt [right] calf decub [decubitus/pressure ulcer]. During an interview on [DATE] at 1:27 p.m., with Resident 1 ' Responsible Party (RP), RP stated prior to Resident 1 falling, she used to live in an assisted living facility, in her own apartment. Resident 1 could inject herself insulin on her stomach after the staff prepared the insulin. Resident 1 could walk to and from the dining hall with the use of front wheeled walker. RP stated Resident 1 could have a conversation. RP stated currently, Resident 1 not very verbal and she could only respond in a Yes or No answer on somedays. RP stated Resident 1 was discharge on [DATE], with hospice (specialized care that support a person nearing the end of life) care. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility ' s policy and procedure (P&P) titled Skin Integrity Management with effective date of [DATE], the P&P indicated The implementation of an individual patient ' s skin integrity management occurs within the care delivery process. Staff continually observes and monitors patients for changes and implements revisions to the plan of care as needed . 2.1 Complete risk evaluation on admission/re-admission, weekly for the first month, quarterly, and with significant change in condition. 3. Identify patient ' s skin integrity status and need for prevention intervention or treatment modalities through review of all appropriate assessment information. 3.1 Perform skin inspection on admission/re-admission and weekly. Document on Treatment Administration Record (TAR) or in Point Click Care [electronic health records] (PCC). 3.2 Perform wound observations and measurements upon initial identification of altered skin integrity, weekly, and with anticipated decline of wound.