STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056065	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Cruz Post Acute	1115 Capitola Road Santa Cruz, CA 95062

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36623 Based on interview and record review, the facility failed to ensure care and services were provided in accordance with professional standards of practice for three of four sampled residents (Residents 1, 2, and 3) when: 1. Resident 1's Daily Skilled Charting documentation (documentation including symptoms review [head to toe review of any symptoms a person is experiencing] and assessment of the body systems [such as neurological (mental status and alertness), cardiovascular (examination of the heart), respiratory (examination of lungs and breathing), skin (examination of color, skin integrity), etc.]) from 11/7/23 to 11/16/23 was completed by a licensed vocational nurse working remotely, without physically seeing the resident. The Daily Skilled Charting documentation was not an accurate summary of the assessment and/or care provided to Resident 1 and did not accurately describe Resident 1's condition. The facility did not identify Resident 1's pressure ulcers (injury to skin and tissue below the skin caused from prolonged pressure on the skin). Resident 1 did not have a urinary catheter (a device inserted in the urinary tract to drain urine from bladder) care plan and there was no documentation that urinary catheter care was performed. Resident 1's physician order for laboratory tests were not completed as ordered. 2. Resident 2's Daily Skilled Charting documentation from 1/3/24 to 1/20/24 and from 1/22/24 to 2/1/24, was completed by licensed vocational nurses working remotely, without physically seeing the resident. The Daily Skilled Charting documentation was not an accurate summary of the assessment and/or care provided to Resident 2 and did not accurately describe Resident 2's condition. 3. Resident 3's Daily Skilled Charting documentation from 3/18/24 to 3/28/24 was completed by licensed vocational nurses working remotely, without physically seeing the resident. The Daily Skilled Charting documentation was not an accurate summary of the assessment and/or care provided to Resident 3 and did not accurately describe Resident 3's condition. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	These failures resulted in the facility not accurately summarizing and documenting the medical and physical conditions of Residents 1, 2, and 3 and the care provided to the residents. This failure had the potential to result in not providing necessary care and treatment for Residents 2 and 3. Assessments are the bases for residents' plan of care and provision of appropriate interventions. Resident 1's laboratory tests aimed to monitor the progress of the resident's clinical condition were not completed as ordered, so Resident 1's doctor could not provide orders accordingly. Resident 1 had hypotension (low blood pressure) and tachycardia (increased heart rate) and was transferred to a hospital's emergency department (ED) on 11/17/23 and pressure ulcers to the coccyx (tailbone) and left ankle were identified in the ED. She was admitted to the intensive care unit (ICU, a unit in a hospital that provides specialized care and treatment for critically ill patients) with overall presentation is consistent with septic shock [widespread infection that causes dangerously low blood pressure] with UTI [urinary tract infection, infection in the urinary system] and right-sided pneumonia [inflammation and fluid in the lungs caused by infection] concerning for aspiration [when food, liquid or other material enters your airway or lungs]. Findings: 1. Review of Resident 1's face sheet (summary page of a patient's important information), printed 2/9/24 indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including meningitis (infection and inflammation of the membranes surrounding the brain and spinal cord), neuromuscular dysfunction of the bladder (loss of bladder control due to brain, spinal cord, or nerve problems), Coronavirus disease 2019 (COVID-19, a contagious disease caused by the coronavirus), and dysphagia (difficulty swallowing). Review of Resident 1's hospital Discharge Summary, dated 11/6/23 indicated Resident 1 tested positive for COVID-19 on 10/31/23. Review of Resident 1's Nursing - Admission/Readmission Evaluation/Assessment, dated 11/6/23 indicated Resident 1 had an indwelling Foley catheter (IFC, a device inserted in the urinary tract and held in the bladder to drain urine), did not have wounds or skin integrity concerns present, and was on droplet precautions (used to prevent the spread of infection through respiratory droplets, staff must wear appropriate personal protective equipment, i.e. gloves, gown, mask) on admission. Review of Resident 1's care plan, dated 11/6/23 indicated, Communicable Disease: resident is at risk for complications related to Coronavirus . isolation precautions as indicated on droplet/contact precaution. Review of Resident 1's Order Summary Report, date range 11/6/23 to 11/17/23, indicated the resident had the following physician orders: - Lidocaine (anesthetic medication used to numb an area or treat pain) Viscous mouth/throat solution 2% Give 5 ml by mouth every four hours as needed for mouth sore before meals and at bedtime, dated 11/6/23; - Divalproex Sodium (Depakote, medication used to treat migraines, seizures, mood disorders) delayed release 500 milligrams 1 tablet by mouth two times a day, dated 11/6/23; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Depakote laboratory level (test to determine whether the medication is at a therapeutic or toxic level) every three months starting on 11/13/23, dated 11/7/23; - Laboratory tests (labs), CBC (complete blood count, test to determine the number of red blood cells, white blood cells, etc.) and BMP (basic metabolic panel, test to determine level of sugar, electrolytes, etc. in the blood) on 11/10/23, dated 11/7/23; - Voiding trial: remove foley catheter and bladder scan every 4 hours. Reinsert foley if bladder scan is greater than 300 milliliters (ml, unit of measurement), dated 11/9/23 (until 11/14/23); - Skilled speech therapy (ST) four times a week for four weeks to include oral function therapy effective 11/12/23 for an increase in pain with swallowing, signs and symptoms of dysphagia, risk for weight loss, dated 11/12/23; - Lidocaine Viscous mouth/throat solution 2% Give 5 ml by mouth before meals for mouth-throat, dated 11/14/23; - Voiding trial: remove foley catheter and bladder scan every 4 hours. Straight cath (intermittent catheterization, insert a small tube through the urinary tract into the bladder to drain urine) if bladder scan is greater than 300 mL, dated 11/14/23. Review of Resident 1's IDT (interdisciplinary team, a group of health care professionals from diverse fields who work toward a common goal for residents) Conference Notes, dated 11/8/23 indicated the resident was noted with swallowing difficulty and a speech therapist (ST) would evaluate the patient. Review of Resident 1's Dietary Note, dated 11/10/23 indicated, RD [Registered Dietician] was informed by staff member that pt [Resident 1] is having difficulty eating regular texture foods. Will downgrade pt to puree. ST to complete evaluation ASAP [as soon as possible]. Review of Resident 1's Speech Therapy SLP (Speech-Language Pathologist, speech therapist) Evaluation and Plan of Treatment, dated 11/12/23 indicated, Reason for Referral - Dysphagia Therapy: [Resident 1] referred to SLP due to new onset of risk for aspiration, risk for dehydration, risk for weight loss, safety during oral intake and signs/symptoms of dysphagia causing change in swallowing abilities related to generalized weakness, aseptic meningitis. [Resident 1] arrives with COVID positive and is on isolation. [Resident 1] expressing pain in her throat with swallowing. Review of Resident 1's Speech Therapy Treatment Encounter Note, dated 11/12/23 indicated Resident 1 was seen by speech therapy on 11/12/23 and she still complained of pain with swallowing. Review of Resident 1's Speech Therapy Treatment Encounter Note, dated 11/14/23 indicated Resident 1 was seen by speech therapy on 11/14/23 and her pain is in the throat with swallowing. Review of Resident 1's Speech Therapy Treatment Encounter Note, dated 11/15/23 indicated Resident 1 was seen by speech therapy on 11/15/23. Review of Resident 1's Physician Progress Note, dated 11/13/23 indicated, Repeat labs ordered but results not posted yet. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 1's lab results indicated there was no documented evidence that Resident 1 had lab results for the ordered labs. Resident 1 did not have a Depakote lab level on 11/13/23. Resident 1 did not have a CBC and BMP done on 11/10/23. Review of Resident 1's care plans indicated Resident 1 did not have a care plan regarding urinary catheter use. Review of Resident 1's physician orders indicated Resident 1 did not have any physician orders regarding the care of a urinary catheter. Review of Resident 1's clinical record indicated there was no documentation regarding Resident 1's assessment of the urine and IFC care. Review of Resident 1's Nursing - Daily Skilled Charting Forms, dated 11/7/23 to 11/16/23, documented by Licensed Vocational Nurse A (LVN A) indicated the Outcomes of Physical Assessment/Observation (performing a physical assessment includes the techniques of inspection [to look at something carefully], palpation [the method of using fingers or hands to touch and feel to examine a body part], percussion [the technique of examining body parts by tapping it with the fingers or an instrument to produce a sound/vibration], and auscultation [listening to the sounds of the body] to gather data) were the following: - Respiratory: breath sounds, clear; - Digestive Status: Bowel sounds, present; - Swallowing/Nutritional Status 1. Any difficulty swallowing noted or complaint of painful swallowing during meal/or swallowing medication? No; - Renal Status: Not Applicable (N/A); - Integumentary [skin] Status: N/A; - Immunological [related to infection] Status: N/A; - Therapy: Physical Therapy and Occupational Therapy [PT/OT]. Further review of Resident 1's Nursing - Daily Skilled Charting Forms, indicated the forms dated 11/7/23, 11/8/23, 11/9/23 were signed on 11/14/23, the form dated 11/10/23 was signed on 11/13/23, and the form dated 11/11/23 was signed on 11/16/23. Review of the forms also indicated the following: - The forms dated 11/7/23 and 11/8/23 did not indicate Resident 1's use of an indwelling catheter or whether catheter care was provided. - The forms dated 11/9/23 to 11/16/23 did not indicate Resident 1 was provided intermittent catheterization. - The forms dated 11/8/24, 11/10/24, 11/12/24, and 11/14/23, did not indicate Resident 1's difficulty swallowing/complaint of painful swallowing. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The forms dated 11/14/23 to 11/16/23 did not indicate Resident 1's nutrition intervention, Lidocaine Viscous mouth/throat solution 2%, for swallowing issues. - The forms dated 11/12/23, 11/14/23 and 11/15/23 did not indicate Resident 1 was seen by speech therapy (Speech Language Pathology, SLP). - The forms dated from 11/7/23 to 11/10/23 did not indicate Resident 1's isolation related to COVID-19 infection. - The forms dated from 11/7/23 to 11/16/23 did not indicate Resident 1 had skin issues. Review of Resident 1's SNF (Skilled Nursing Facility) to Hospital Transfer form, dated late entry (documented on a later date) on 11/28/23, indicated the resident was discharged to the hospital on 11/17/23 (time not specified) due to hypotension and tachycardia. The form also indicated Resident 1 had no pressure ulcers/injuries and had a urinary catheter in place. Review of Resident 1's hospital Emergency Department (ED) Physician Notes, dated 11/17/23 at 5:31 p.m., indicated, She arrives febrile [showing symptoms of a fever], tachycardic [increased heart rate], and hypotensive [low blood pressure], is critically ill . [Resident 1] has leukocytosis [increased white blood cells, which help fight infection] with significant bandemia [increased levels of band cells (immature white blood cells)]. This is quite concerning. She has elevated sodium that is critically high. This suggest free water deficit [increased sodium and insufficient water]. Her chloride is also high. Her BUN [blood urea nitrogen] and creatinine [indicator of kidney health] are markedly elevated compared to her baseline of about 0.6. Lactic acid [formed when the body breaks down carbohydrates to use for energy] is elevated above 2 which indicates at least severe sepsis in this febrile hypotensive patient . Urine looks quite infected . Overall presentation is consistent with septic shock with UTI and right-sided pneumonia concerning for aspiration . Admit to ICU for ongoing care and evaluation. The notes also indicated Resident 1 had a decubitus ulcer (pressure ulcer). Review of Resident 1's hospital History and Physical, dated 11/17/23 indicated, [Patient 1] came to [hospital] without a Foley catheter as they were trying a voiding trial, however when Foley was placed here, there was very cloudy thick urine . pressure ulcer on sacrum [bone at the base of the spine] noted on admission, nursing will photograph. Review of Resident 1's hospital Wound Care Photo, dated 11/17/23 indicated three pictures were taken of Resident 1s coccyx wound in the ER (emergency room , ED) on 11/17/23. Review of Resident 1's hospital Wound Care Photo, dated 11/17/23 indicated one picture was taken of Resident 1's left outer ankle wound in theER on [DATE]. Review of Resident 1's hospital Wound Care Note, dated 11/18/23 indicated Resident 1 had two wounds discovered on 11/17/23: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Resident 1's Wound 1 was an unstageable pressure injury (pressure injury unable to determine the stage; staging/classification system uses depth to classify ulcers) on the coccyx, measuring 2.5 centimeters (cm, unit of measurement) by 3.5 cm x 0.2 cm. The wound bed had slough [dead tissue], peeling skin, dark non blanchable [discoloration of the skin that does not turn white when pressed] tissue and clean non gran [absence of granulation, which is an important component in the wound healing process] pink tissue. - Resident 1's Wound 2 was a deep tissue pressure injury to the left lateral ankle. Wound 2 was described as Dark non blanchable tissue over Lat [lateral, to the side] malleolus [ankle bone] with boggy [soft, abnormal texture of tissue] blistered center. During an interview with LVN A on 4/2/24 at 3:22 p.m., LVN A confirmed she completed the Daily Skilled Charting Forms for Resident 1 on the above dates remotely (not physically present, working from a location other than the actual physical work location), including the skin assessments. LVN A stated she was not physically present in the facility when she documented Daily Skilled Charting Forms for Resident 1 and other residents since November 2023. LVN A also stated she based her assessment documentation including the symptoms review (head to toe review of any symptoms a person is experiencing), assessment of the body systems (such as neurological [mental status and alertness], cardiovascular [examination of the heart], respiratory [examination of lungs and breathing], skin, etc.) and pain assessments from the previous progress notes of nurses, MD (doctor of medicine), and PT/OT. LVN A acknowledged that the assessment should not be based on the documents of others, but she should be physically present to perform the resident's assessment herself. During an interview on 5/16/24 at 2:42 p.m. with the human resources manager (HRM), the HRM stated LVN A is a regional minimum data set (MDS) nurse. The HRM stated LVN A's work is done remotely. When asked whether LVN A had a signed job description for the regional MDS nurse, HRM stated there was none. During an interview on 5/16/24 at 3:40 p.m., the director or nursing (DON) stated for residents with urinary catheter, they should have catheter care every shift, urinary catheter orders, and a care plan. The DON confirmed Resident 1 did not have a care plan regarding urinary catheter. The DON also confirmed there were no physician orders related to Resident 1's indwelling catheter. She confirmed there was no documentation of the description of Resident 1's urine. The DON also stated if doing a physical assessment, including daily skilled charting, it should be done while staff was present in the facility. During an interview on 5/16/24 at 3:53 p.m., the DON confirmed there was no documentation that indicated Resident 1 had any laboratory tests done. Resident 1 did not have a Depakote lab level on 11/13/23 and Resident 1 did not have a CBC and BMP done on 11/10/23. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/4/24 at 1:40 p.m., the DON stated the Daily Skilled Charting Forms were a summary of the care provided that day as indicated as effective date. The DON acknowledged Resident 1's Daily Skilled Charting Forms indicated Resident 1 did not have difficulty/painful swallowing, and N/A was checked for renal status, integumentary status, and immunological status. She stated if Resident 1 had an indwelling catheter, the Daily Skilled Charting should have had indwelling catheter checked. The DON stated if Resident 1 had intermittent catheterization, the Daily Skilled Charting should have had intermittent catheterization checked on the days it was provided. She also stated she would not be documenting breath sounds without physically assessing the resident. The DON further stated if Resident 1 had any problems that day, she expected it to reflect in the Daily Skilled Charting documentation. The DON stated for Resident 1, isolation should have been checked from admission (11/6/23) to 11/10/23. During an interview on 6/5/24 at 2:17 p.m., the DON stated the Daily Skilled Charting Form is documented based on the day it is dated. She stated the facility's goal is to complete the Daily Skilled Chartings within 72 hours. Review of an article from the National Library of Medicine, Physical Assessment Competencies for Nurses: A Quality Improvement Initiative, published 4/17/22 indicated, Physical assessment is a basic but essential nursing skill. Being able to assess the patient's current condition can help identify early changes. Knowledge of a patient's clinical status and usual behaviors gained through a full (head-to-toe) physical assessment is a key influence on a nurse's ability to recognize subtle changes in a patient's condition. Review of an article, LVN Scope of Practice in California 2024: A Comprehensive Guide, dated 3/7/24 from the National Career College website indicated, While LVNs can perform basic health assessments, conducting comprehensive physical examinations and developing care plans are the responsibilities of RNs [Registered Nurses] and physicians. Review of the facility's Job Description: MDS Coordinator LPN [Licensed Practical Nurse]/LVN, dated 7/2020 indicated, The primary purpose of you job position is to provide direct nursing care to residents . Chart nurses' notes in an informative and descriptive manner that reflects the care provided to the resident . Perform charting duties as required and in accordance with established charting and documentation policies and procedures. Review of the facility's policy, Charting and Documentation, dated 2001 indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial (involves the interaction between a person's thoughts and behaviors with a social environment) condition, shall be documented in the resident's medical record . The following information is to be documented in the resident medical record: a. Objective observations . Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. Review of the facility's policy and procedure (P&P), Urinary Catheter Care, dated 2001, indicated, the purpose of this procedure is to prevent urinary catheter-associated complications, including UTI. The P&P indicated to use soap and water or bathing wipes for routine daily hygiene. The P&P also indicated, The following information should be recorded in the resident's medical record: 1. The date and time that catheter care was given. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Pressure injury to Sacrococcygeal area - Wound VAC (Vacuum Assisted Closure, a device used to decrease air pressure and help to heal a wound) orders- cleanse with Dakin's solution (an antiseptic used to cleanse wounds to prevent infection) quarter strength, rinse with NS, pat dry, skin prep to peri wound. Apply black foam to wound bed and cover with Tegaderm, set to continuous therapy, 125 mmHg (millimeters of mercury, measurement of pressure), change three days a week, every day shift every Tue, Thu, Sat for pressure injury wound vac and as needed, dated 1/31/24. Review of Resident 2's Nursing - Daily Skilled Charting Forms, dated 1/3/24 to 1/20/24 and 1/22/24 to 2/1/24, indicated the Outcomes of Physical Assessment/Observation were the following: - Respiratory: breath sounds, clear; - Digestive Status: Bowel sounds, present; - Integumentary [skin] Status: Wounds, Wound Sites and Treatments, GT site R (right) side of head. The Daily Skilled Charting forms dated 1/3/24 to 1/20/24 and 1/22/24 to 2/1/24 did not indicate Resident 2's wound to the sacrococcygeal area and/or treatments to the wound. Further review of Resident 2's Nursing - Daily Skilled Charting Forms indicated the form dated 1/19/24 was signed on 1/23/24. Review of the forms also indicated the following: - Resident 2's Nursing - Daily Skilled Charting Forms, dated 1/6/24, 1/7/24, 1/13/24, 1/14/24, 1/20/24, 1/27/24, and 1/28/24, indicated the forms were documented by LVN A. - Resident 2's Nursing - Daily Skilled Charting Forms, dated 1/3/24 to 1/25/24, 1/8/24 to 1/12/24, 1/15/24 to 1/19/24, 1/22/24 to 1/26/24, and 1/29/24 to 2/1/24 indicated the forms were documented by LVN B. During an interview with LVN A on 4/2/24 at 3:22 p.m., LVN A stated she was not physically present in the facility when she documented Daily Skilled Charting Forms for Resident 2 and other residents since November 2023. LVN A stated she based her documentation from the previous progress notes of nurses, MD, and PT/OT. LVN A acknowledged that the assessment should not be based on the documentation or notes of others, but she should be physically present to perform the resident's assessment herself. During an interview on 6/4/24 at 12:37 p.m. LVN B confirmed she did not perform the actual physical assessments when she completed the residents' Daily Skilled Charting Forms. LVN B stated she worked from home and would document the Daily Skilled Charting based on what is documented in the resident's chart. LVN B stated if there were no progress notes or any resident changes documented, she would not make any changes to the Daily Skilled Charting Forms and would document what was documented the previous day. When told Resident 2's pressure ulcer was not documented in Resident 2's Daily Skilled Charting, LVN B replied, Okay. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/5/24 at 1:40 p.m., the DON confirmed Resident 2 had a pressure ulcer and was on a wound VAC treatment. She confirmed Resident 2's Daily Skilled Charting Forms did not indicate the resident had a pressure ulcer and pressure ulcer treatment. The DON stated she would expect Resident 2's Daily Skilled Charting Forms to indicate Resident 2 had a sacrococcygeal wound. 3. Review of Resident 3's clinical record indicated he was admitted to the facility with diagnoses including metabolic encephalopathy (disease that affects brain function caused by a chemical imbalance in the blood) and UTI. Review of Resident 3's Nursing - Admission/Readmission Evaluation/Assessment, dated 3/17/24 indicated he had recurrent UTI, had in indwelling Foley catheter, and his urine was dark in color upon admission. Review of Resident 3's physician orders indicated he had an order, dated 3/18/24 of an indwelling urinary catheter for urinary retention. Review of Resident 3's Nursing - Daily Skilled Charting Forms, dated 3/18/24 to 3/28/24, indicated the Outcomes of Physical Assessment/Observation were the following: Respiratory: breath sounds, clear; Digestive Status: Bowel sounds, present; Renal Status: N/A; The forms dated 3/18/24 to 3/28/24, did not indicate Resident 3's use of an indwelling catheter. Review of Resident 3's Nursing - Daily Skilled Charting Forms, dated 3/23/24, 3/24/24, indicated the forms were documented by LVN A. Review of Resident 3's Nursing - Daily Skilled Charting Forms, dated 3/18/24 to 3/22/24, and 3/25/24 to 3/28/24, indicated the forms were documented by LVN B. During an interview with LVN A on 4/2/24 at 3:22 p.m., LVN A stated she was not physically present in the facility when she documented Daily Skilled Charting Forms for residents since November 2023. LVN A stated she based her documentation from the previous progress notes of nurses, MD, and PT/OT. LVN A acknowledged that the assessment should not be based on the documents of others, but she should be physically present to perform the assessment herself with the resident. During an interview on 6/4/24 at 12:37 p.m. LVN B confirmed she did not perform physical assessments. She stated she worked from home and would document the Daily Skilled Charting Forms based on what was documented in the resident's chart. LVN B stated if there were no progress notes or any resident changes documented, she would not make any changes to the Daily Skilled Charting Forms and would document what was documented the previous day. She stated she stopped completing Daily Skilled Charting Forms remotely in March because of a survey that found that foley catheter was not checked when it should have been checked. LVN B stated now the Daily Skilled Charting Forms are supposed to be completed by the nurses physically caring for the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056065	A. Building B. Wing	06/18/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/4/24 at 1:40 p.m., the DON confirmed Resident 3 had an indwelling catheter the while he was at the facility. The DON confirmed Resident 3's Daily Skilled Charting Forms did not have indwelling catheter checked. She stated Resident 3's Daily Skilled Charting Forms should have had indwelling catheter checked. Review of an email, dated 6/20/24 from the administrator (ADM) indicated LVN A and LVN B documented in the Daily Skilled Charting Forms for 74 residents in November 2023, 68 residents in December 2023, 75 residents in January 2024, 83 residents in February 2024, and 86 patients in March 2024. Review of an article from the National Library of Medicine, Physical Assessment Competencies for Nurses: A Quality Improvement Initiative, published 4/17/22 indicated, Physical assessment is a basic but essential nursing skill. Being able to assess the patient's current condition can help identify early changes. Knowledge of a patient's clinical status and usual behaviors gained through a full (head-to-toe) physical assessment is a key influence on a nurse's ability to recognize subtle changes in a patient's condition. Review of an article, LVN Scope of Practice in California 2024: A Comprehensive Guide, dated 3/7/24 from the National Career College website indicated, While LVNs can perform basic health assessments, conducting comprehensive physical examinations and developing care plans are the responsibilities of RNs [Registered Nurses] and physicians. Review of the facility's Job Description: MDS Coordinator LPN/LVN, dated 7/2020 indicated, The primary purpose of you job position is to provide direct nursing care to residents . Chart nurses' notes in an informative and descriptive manner that reflects the care provided to the resident . Perform charting duties as required and in accordance with established charting and documentation policies and procedures. Review of the facility's policy, Charting and Documentation, dated 2001 indicated, All services provided to the resident, 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 following information is to be documented in the resident medical record: a. Objective observations . Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.

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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** 36623 Based on interview and record review the facility failed to ensure care and services were provided in accordance with professional standards of practice in performing accurate skin assessment to help prevent pressure ulcers (injury to skin and tissue below the skin caused from prolonged pressure on the skin) and provide necessary pressure treatment for one of three residents when staff failed to identify the presence of pressure ulcers for Resident 1. This failure resulted in Resident 1 not receiving pressure ulcer treatment and nursing interventions to aid in wound healing. When Resident 1 was transferred to a hospital's emergency department (ED) on 11/17/23, an unstageable pressure injury (unable to determine the stage; staging/classification system uses depth to classify ulcers) to the coccyx (tailbone) and deep tissue pressure injury (intact or non-intact skin with persistent, deep red, maroon, or purple discoloration) to the left ankle were identified in the ED upon initial physical assessment. Findings: 1. Review of Resident 1's face sheet (summary page of a patient's important information), printed 2/9/24 indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including meningitis (infection and inflammation of the membranes surrounding the brain and spinal cord) and neuromuscular dysfunction of the bladder (loss of bladder control due to brain, spinal cord, or nerve problems). Review of Resident 1's Nursing - Admission/Readmission Evaluation/Assessment, dated 11/6/23 indicated Resident 1 did not have wounds or skin integrity (condition of skin's barrier) concerns present on admission. Review of Resident 1's Braden Scale for Predicting Pressure Sore Risk, dated 11/6/24 indicated the resident's score was 17. A score of 15-18 indicated she was at risk for developing a pressure sore. Review of Resident 1's IDT (interdisciplinary team, a group of health care professionals from diverse fields who work toward a common goal for residents) Conference Notes, dated 11/8/23 indicated the resident had no pressure ulcers and she was at risk for skin breakdown due to age and immobility. Review of Resident 1's Nursing - Daily Skilled Charting Forms (documentation including symptoms review [head to toe review of any symptoms a person is experiencing] and assessment of the body systems [such as neurological (mental status and alertness), cardiovascular (examination of the heart), respiratory (examination of lungs and breathing), skin (examination of color, skin integrity), etc.], dated 11/7/23 to 11/16/23, documented by Licensed Vocational Nurse A (LVN A) indicated the Outcomes of Physical Assessment/Observation (performing a physical assessment includes the techniques of inspection [to look at something carefully], palpation [the method of using fingers or hands to touch and feel to examine a body part], percussion [the technique of examining body parts by tapping it with the fingers or an instrument to produce a sound/vibration], and auscultation [listening to the sounds of the body] to gather data) were the following: -Respiratory: breath sounds, clear; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Digestive Status: Bowel sounds, present; -Integumentary (skin) Status: Not Applicable (N/A); Further review of the Daily Skilled Charting forms dated from 11/7/23 to 11/16/23, documented by LVN A, the daily assessments did not indicate Resident 1 had skin issues. There were no check marks on the following check boxes to describe Resident 1's skin status: skin color normal, warm, dry, cool, chills, intact, cyanosis (bluish discoloration due to lack of circulation or oxygen), redness, jaundiced (yellow discoloration), pallor (pale appearance), clammy (moist/sweaty), flushing of skin (reddening of the face or neck area), rash/itching, edema (swelling), burns, and wounds. The only box checked for skin status was N/A. Review of Resident 1's progress notes from 11/6/23 to 11/17/23 indicated there was no documented evidence staff identified any skin issues or pressure ulcers for Resident 1. There was no documented evidence staff implemented nursing interventions to treat skin issues or pressure ulcers to aid in wound healing. Review of Resident 1's Order Summary Report, date range 11/6/23 to 11/17/23 indicated there were no orders for pressure ulcer treatment. Review of Resident 1's SNF (Skilled Nursing Facility) to Hospital Transfer form, dated late entry (documented on a later date) on 11/28/23, indicated the resident was transferred to the hospital on 11/17/23 (time not specified) due to hypotension (low blood pressure) and tachycardia (increased heart rate). The form also indicated Resident 1 had no pressure ulcers/injuries. Review of Resident 1's hospital Emergency Department (ED) Physician Notes, dated 11/17/23 at 5:31 p.m., indicated the Physical Examination identified Resident 1 had a decubitus ulcer (pressure ulcer). Review of Resident 1's hospital History and Physical (formal document created by a physician based on patient interview, physical exam, and summary of tests) dated 11/17/23 indicated, [Patient 1] came to [hospital] . pressure ulcer on sacrum [bone at the base of the spine] noted on admission, nursing will photograph. Review of Resident 1's hospital Wound Care Photo, dated 11/17/23 indicated three pictures were taken of Resident 1's coccyx wound in the ER (emergency room , ED) on 11/17/23. Review of Resident 1's hospital Wound Care Photo, dated 11/17/23 indicated one picture was taken of Resident 1's left outer ankle wound in theER on [DATE]. Review of Resident 1's hospital Wound Care Note, dated 11/18/23 indicated Resident 1 had two wounds discovered on 11/17/23: -Resident 1's Wound 1 was an unstageable pressure injury on the coccyx, measuring 2.5 centimeters (cm, unit of measurement) by 3.5 cm x 0.2 cm. The wound bed had slough [dead tissue], peeling skin, dark non blanchable [discoloration of the skin that does not turn white when pressed] tissue and clean non gran [absence of granulation, which is an important component in the wound healing process] pink tissue. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Resident 1's Wound 2 was a deep tissue pressure injury to the left lateral ankle. Wound 2 was described as Dark non blanchable tissue over Lat [lateral, to the side] malleolus [ankle bone] with boggy [soft, abnormal texture of tissue] blistered center. During interviews from 3/18/24 to 3/28/24 with LVNs and certified nursing assistants (CNA) who cared for Resident 1, the LVNs and CNAs stated they did not remember pressure ulcers identified for Resident 1. During an interview with LVN A on 4/2/24 at 3:22 p.m., LVN A confirmed she completed the Daily Skilled Charting Forms for Resident 1 on the above dates remotely (not physically present, working from a location other than the place where the residents currently reside), including the skin assessments. LVN A stated she was not physically present in the facility when she documented Daily Skilled Chartings for Resident 1 and other residents since November 2023. LVN A also stated she based her assessment documentations including the symptoms review (head to toe review of any symptoms a person is experiencing), assessment of the body systems (such as respiratory [examination of lungs and breathing], skin [requires inspection and palpation to determine color, skin integrity], etc.) and pain assessments from the previous progress notes of nurses, MD (doctor of medicine), and PT/OT (physical therapy and occupational therapy). LVN A acknowledged that the assessment should not be based on the documents of others, but she should be physically present to perform the resident's assessment herself. During an interview on 5/16/24 at 2:42 p.m. with the human resources/payroll manager (HRPM), the HRPM stated LVN A is a regional minimum data set (MDS) nurse. The HRPM stated LVN A's work is done remotely. When asked whether LVN A had a signed job description for the regional MDS nurse, HRPM stated there was none. During an interview on 5/16/24 at 3:40 p.m., the director or nursing (DON) stated when doing a physical assessment, including documentation for Daily Skilled Charting, it should be done while staff was present in the facility. During an interview on 6/4/24 at 1:40 p.m., the DON acknowledged Resident 1's Daily Skilled Charting Forms, dated 11/7/23 to 11/16/23 indicated N/A was checked for integumentary status for Resident 1. She also stated she would not be documenting breath sounds and bowel sounds without physically assessing the resident. The DON further stated if Resident 1 had any problems that day, she expected it to reflect in the Daily Skilled Charting documentation. Review of an article from the National Library of Medicine, Physical Assessment Competencies for Nurses: A Quality Improvement Initiative, published 4/17/22 indicated, Physical assessment is a basic but essential nursing skill. Being able to assess the patient's current condition can help identify early changes. Knowledge of a patient's clinical status and usual behaviors gained through a full (head?to?toe) physical assessment is a key influence on a nurse's ability to recognize subtle changes in a patient's condition. Review of an article, LVN Scope of Practice in California 2024: A Comprehensive Guide, dated 3/7/24 from the National Career College website indicated, While LVNs can perform basic health assessments, conducting comprehensive physical examinations and developing care plans are the responsibilities of RNs [Registered Nurses] and physicians. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's policy, Charting and Documentation, dated 2001 indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial (involves the interaction between a person's thoughts and behaviors with a social environment) condition, shall be documented in the resident's medical record . The following information is to be documented in the resident medical record: a. Objective observations . Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. Review of the facility's Job Description: MDS Coordinator LPN [Licensed Practical Nurse]/LVN, dated 7/2020 indicated, The primary purpose of you job position is to provide direct nursing care to residents . Chart nurses' notes in an informative and descriptive manner that reflects the care provided to the resident . Perform charting duties as required and in accordance with established charting and documentation policies and procedures.