STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056207	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Gardens Nursing and Rehabilitation Center	577 S. Peach Ave. Fresno, CA 93727

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** 44899 Based on interview and record review, the facility failed to ensure one of three residents (Resident 1) did not develop pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) when Resident 1 was assessed as a moderate risk for developing pressure ulcers and the nursing care plan of daily and weekly skin assessments was not implemented from 1/6/24 to 1/19/24 for early recognition of skin changes and implementation of appropriate interventions to prevent pressure ulcer. These failures resulted in Resident 1 to develop a preventable Stage 3 (full thickness skin loss involving damage or death of the deepest layer of the skin that may extend down to, but not through, underlying connective tissues) pressure ulcer to the sacrum (located at the bottom of the spine, near the tail bone or coccyx) area. Findings: During a review of the clinical record for Resident 1, the Admission Record (record containing resident demographic information), undated, the Admission Record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included Acute Respiratory Failure (a serious condition that makes it difficult to breathe), Generalized Muscle Weakness, Hypertension (high blood pressure), Mild Cognitive Impairment (decline in memory and thinking), Pneumonia (lung infection caused by bacteria), and Morbid Obesity (a complex disease involving appetite regulation and energy consumption). During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool used to identify resident mental and physical functional level) assessment dated [DATE], the MDS indicated Resident 1's Brief Interview for Mental Status (BIMS-assessment of cognitive status for memory and judgement) assessment score of 9 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderate impairment, and 00-07 indicates severe impairment) indicating Resident 1 had moderate cognitive deficits. During a review of the facility policy and procedure (P&P) titled Skin Integrity dated 8/1/14, the P&P indicated, . Residents identified to be at risk for skin breakdown (pressure ulcers) will have a routine assessment and interdisciplinary (IDT) care plan process implemented to maintain and/or improve skin integrity . 2. New admission residents will have a skin assessment on admission then weekly for three weeks . 4. Communication by Certified Nurse Assistant (CNA) to licensed nurse utilizing a skin condition worksheet or comparable document . 15. Weekly head to toe assessment will be completed of all residents by a Licensed nurse . (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 phone interview on 2/2/24, at 1:00 p.m., with General Acute Care Medical Social Worker (MSW), MSW stated she filed a complaint to the local Ombudsman (advocates for nursing home residents) office and the California Department of Public Health (CDPH, a government agency for the State of California in charge of protecting the public's health and helping shape positive health outcomes for individuals, families and communities) on 1/29/24 regarding Resident 1's facility-acquired pressure ulcer. MSW stated Resident 1 was transferred to Skilled Nursing Facility (SNF, a place where trained nurses in a medical setting are providing care to patients to continue recovering after an illness, injury or surgery) on 1/6/24 for rehabilitation and with no pressure ulcers or open skin. MSW stated Resident 1 was readmitted to acute hospital on 1/25/24 due to abnormal vital signs (clinical data, such as pulse rate, temperature, respiration rate, and blood pressure, that indicate the state of a patient's essential body functions) and with stage 3 pressure ulcer to her sacrum area. MSW stated she was concerned about the quality of care being provided by the facility to its residents. During a phone interview on 2/4/24, at 11:14 a.m., with Certified Nurse Aide (CNA) 1, CNA 1 stated he was the assigned CNA to care for Resident 1 on 1/19/24, from 3:00 p.m. to 11:30 p.m. CNA 1 stated, I'm a new CNA and it was my first time to work in that nursing unit and to care for [Resident 1]. She does not move much. She stayed in her bed for the duration of my shift. She has a urinary catheter [a flexible tube used to empty the bladder and collect urine in a drainage bag]. CNA 1 stated at approximately 9:00 p.m., he went to Resident 1's room to check and change her disposable brief. CNA 1 stated, She [Resident 1] had a bowel movement and while doing peri-care, I noticed an open area to her sacrum area. I immediately reported it to [RN 1]. The nurse came to the room and I assisted her [RN 1] by holding [Resident 1]'s back while she's assessing and measuring the wound. CNA 1 stated he does not recall receiving a report from the morning CNA regarding [Resident 1] having a pressure ulcer on her sacrum area. CNA 1 stated the task of checking Resident 1's skin was not listed on her care plan. CNA 1 stated he was not aware of the care plan intervention of assessing Resident 1's skin twice a day. During a concurrent interview and record review on 2/5/24, at 7:25 p.m., with Registered Nurse (RN) 1, RN 1 stated she was the license nurse assigned to care for Resident 1 on 1/6/24. Resident 1's Admission Note (AN), dated 1/6/24 was reviewed. The AN indicated, . 18:41 [6:41 p.m.] . 14. Skin note: Rash to perianal area [area between the genitals and anus], laceration [cut] to left medial [towards the middle] high, bruises to right dorsum [back] hand, swelling to left lateral malleolus [bone located at the ankle], swelling to right medial malleolus . RN 1 stated she was unable to find a documentation of Resident 1 having pressure ulcer to her sacrum area on admission. During a concurrent interview and record review on 2/5/24, at 7:39 p.m., with RN 1, Resident 1's Nursing Progress Note (NPN) and Change in Condition Report (COC), dated 1/19/24 were reviewed. RN 1 stated she was the assigned RN to care for Resident 1 on 1/19/24, from 3:00 p.m. to 11:30 p.m. The NPN indicated, . 22:19 [10:19 p.m.] . CNA informed the writer that resident has [pressure] ulcer on her back. Writer went into the room and assessed the resident . The COC indicated, . 22:29 [10:29 p.m.] . pressure injury on sacrum, and three to five small bones fuse to create the coccyx] . this start on: 01/19/2024 . RN 1 stated she provided nursing care to Resident 1 since admission, and she was not aware of Resident 1 having a pressure ulcer to her sacrum area. RN 1 stated the morning nurse did not mention Resident 1 having a pressure ulcer to her sacrum area during change of shift report. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 2/5/24, at 7:46 p.m., with RN 1, Resident 1's Skin and Wound Evaluation, dated 1/20/24 was reviewed. The evaluation indicated, . 01:38 [1:38 a.m.] . Type: Pressure . Stage: Stage 3: Full-thickness skin loss . Location: Sacrum, Medical . Exact Date: 01/19/2024 . Wound Measurements: Area 36.4 cm (centimeter, unit of measurement) . Length 8.5 cm . Width 5.9 cm . RN 1 stated Resident 1's sacrum pressure ulcer was first discovered on 1/19/23 by [CNA 1]. RN 1 stated a stage 3 pressure ulcer was impossible to develop within a couple of hours. RN 1 stated Resident 1's skin was not assessed daily and should have been assessed. During a concurrent interview and record review on 2/5/24, at 7:52 p.m., with RN 1, Resident 1's Nursing Care Plan (CP), dated 1/7/24 was reviewed. The CP indicated, . Focus: Potential for impaired skin integrity related to impaired mobility . Interventions . Observe skin integrity during am/pm [morning/afternoon] care . Date Initiated: 1/6/24 . Evaluate Skin Weekly . Date Initiated: 1/6/24 . RN 1 stated she was unable to find documentation a skin assessment was done during morning and afternoon care from 1/7/24 to 1/19/24. RN 1 stated she was unable to find documentation of weekly skin assessment from 1/7/24 to 1/19/24. RN 1 stated the facility failed to assess Resident 1's skin integrity twice a day and weekly which resulted to the late recognition of a stage 3 pressure ulcer to her sacrum area. During a concurrent interview and record review on 2/6/24, at 10:45 a.m., with the Nursing Supervisor/Assistant Director of Nursing (ADON) 1, Resident 1's Nursing Care Plan (CP), dated 1/7/24 was reviewed. ADON 1 stated she was unable to find documentation a skin assessment was done during morning and afternoon care from 1/7/24 to 1/19/24. ADON 1 stated she was unable to find documentation of weekly skin assessment from 1/7/24 to 1/19/24. ADON 1 stated CNAs and licensed nurses were expected to implement Resident 1's skin integrity care plan and it was not done. During a concurrent interview and record review on 2/6/24, at 10:51 a.m., with the ADON 2, Resident 1's CNA Task Description, undated was reviewed. The document indicated, . Task List . Roll Left & [and] Right every shift . Sit to Lying every shift . ADON 2 stated she was unable to find a specific task to check Resident 1's skin during morning and afternoon care. ADON 2 stated the facility failed to implement Resident 1's skin integrity care plan and did not assess Resident 1's skin twice a day and weekly which resulted to stage 3 pressure ulcer to her sacrum area. ADON 2 stated she and [ADON 1] were the designated clinical leaders for RNs, License Vocational Nurse (LVNs) and CNAs. ADON 2 stated she and [ADON 1] failed to ensure clinical staff were implementing Resident 1's skin integrity care plan. During an interview on 2/6/24, at 11:46 a.m., with the Director of Nursing (DON), the DON stated Resident 1's nursing care plan interventions to prevent skin breakdown should have been implemented on admission and it was not done. The DON stated the facility failed to follow the P&P on Skin Integrity which contributed to Resident 1's development of stage 3 sacrum pressure ulcer. During a review of Resident 1's clinical record titled, BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK, dated 1/6/24, at 6:44 p.m., the document indicated, . 3. ACTIVITY . Bedfast: Confined to bed . 4. MOBILITY . Very Limited. Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently . 6. FRICTION & [and] SHEAR . Problem: Requires moderate to maximum assistance in moving . Score 13 . [AT RISK 15-18, MODERATE RISK 13-14, HIGH RISK 10-12, VERY HIGH RISK 9 or below] . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility policy and procedure (P&P) titled Prevention of Pressure Ulcer undated, the P&P indicated, . BASIC RESPONSIBILITY: Licensed Nurse and Nursing Assistant . 20. Asses for risk of pressure ulcer development . 28. Establish a turning and positioning schedule in bed and chair to meet the resident's needs . Documentation may include . Preventive measures used . Condition of the resident's skin . Goal: List MEASURABLE goal(s) to be accomplished . During a review of the facility's document titled, Job Description . Certified Nursing Assistant (CNA), undated, the document indicated, . Maintain and use current, appropriate clinical knowledge of all required nursing policies and procedures . Provide the clinical and support services needed to meet all physical and psychosocial needs of the residents . Improve and maintain skin integrity and general health and comfort including: Provides skin care interventions as per the plan of care . During a review of the facility's document titled, Job Description . Registered Nurse (RN), undated, the document indicated, . The primary purpose of this position is to function as a collaborative member of the IDT, provide patient quality care, optimal clinical outcomes . Utilizes professional standards in performing assessment and monitoring in accordance with scope of licensure . Develops, implements, evaluates, and updates plans of care accordingly . During a review of the facility's document titled, Job Description . Nursing Supervisor, undated, the document indicated, . The primary purpose of this position is to manage nursing department services on a day-to-day basis to achieve the identified clinical and operational results and assuring resident safety . Conduct clinical assessments; use critical thinking and coordinate professional standards of care . Develop, review, and revise care plans to accurately reflect Resident needs . Supervise nursing staff to maximize clinical outcomes and operations effectives . During a review of professional reference document titled Pressure Injury Prevention Points dated 2016, retrieved from https://npuap.org/page/PreventionPoints, the document indicated, Consider bedfast and chairfast individuals to be at risk for development of pressure injury . Develop a plan of care based on the areas of risk, rather than on the total risk assessment score. For example, if the risk stems from immobility, address turning, repositioning and the support surface . Inspect the skin at least daily for signs of pressure injury . Assess pressure points, such as the sacrum, coccyx, buttocks . Turn and reposition all individuals at risk for pressure injury . Continue to reposition an individual when placed on any support surfaces . Use a pressure redistributing chair cushion for individuals sitting in chairs or wheelchairs . Reposition weak or immobile .