STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056237	A. Building B. Wing	05/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Terrace Convalescent Hospital	1240 S Hoover St Los Angeles, CA 90006

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43321 Based on interview and record review, the facility failed to assess and document a resident's wound to ensure the resident received treatment and care in accordance with the professional standards of practice for one of three sampled residents (Resident 1) as evidenced by failure to: 1. Ensure Licensed Nurses documented he current assessment and or any changes in the resident's medical condition. On dated 5/12/2024 at 7:26 pm, 5/13/2024 at 4 am, 5/13/2024 at 1:07 pm, 5/13/2024 at 7:49 pm and 5/13/2024 at 11:28 pm written by five different nurses (Licensed Vocational Nurse 2 (LVN 2), LVNs 3, 5, and 6 and Registered Nurse 2 (RN 2), indicated the same exact verbiage. 2. Initiate a plan of care when a change of wound condition was identified on 5/12/2024. The Resident 1's care plan titled Blister, Skin Integrity Impairment Secondary to Fluid Filled Blister to Left Upper Extremity, and Risk for Infection. Resident is at: Moderate risk for infection secondary to: Fluid Filled Blister to LUE (left upper extremity), were created on 5/15/2024 when Resident 1 was no longer in the facility. 3.Ensure to inform Wound Care Specialist (WCS, a medical professional who specializes in treating wounds) pertinent information regarding Resident 1 which includes diagnosis of diabetes (high blood sugar) and presence of brown drainage from Resident 1's left arm wound on 5/12/2024. 4. Ensure Licensed Nurses comprehensively assess and document the resident's wound bed color, size, length, width, depth, presence of drainage and discoloration in Resident 1's change of condition assessment dated [DATE] and when there is a notable change in the left arm wound condition. 5.Ensure Licensed Nurses identify the presence of signs and symptoms of infection and report any suspicion of infection for Resident 1 to the attending physician and or to the Wound Care Specialist 1. These deficient practices: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Actual harm Residents Affected - Few	1.Resulted to Resident 1 being admitted to General Acute Care Hospital (GACH 1) with a diagnosis of cellulitis (a deep bacterial infection of the skin characterized by redness, swelling and tenderness) of the left arm and sepsis (a serious condition in which the body responds improperly to an infection). Resident 1 received three different types of antibiotics in the Emergency Department and was recommended to have wound debridement (the medical removal of dead, damaged, or infected tissue to improve the healing potential of the remaining healthy tissue). 2.The potential for Resident 1 not to receive the appropriate treatment and care due to lack of comprehensive documentation by the facility staff regarding Resident 1's condition and response to care. Findings: A review of Resident 1's Admission Record (Face Sheet) indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included type 2 diabetes mellitus (high blood sugar), chronic kidney disease (progressive damage and loss of function in the kidneys), personal history of urinary tract infections (an infection in any part of the urinary tract system which is the system of organs that makes urine), dementia (impaired inability to remember, think, or make decisions that interferes with doing everyday activities), and benign prostatic hyperplasia (prostate gland enlargement) with lower urinary tract symptoms (such as urinating frequently (during the day and night), a weak urine stream, and leaking or dribbling of urine). A review of Resident 1's care plan titled Risk for developing pressure sore (injuries to the skin and underlying tissue, primarily caused by prolonged pressure on the skin; usually affect people confined to bed or who sit in a chair or wheelchair for long periods of time), and other types of skin breakdown related to fragile skin due to (d/t) aging process, dementia, diabetes mellitus type 2 (DM 2), initiated on 10/26/2023, indicated a goal to minimize the risk of skin breakdown / pressure sore daily through the next assessment of 7/28/2024. Interventions included to assess skin integrity during care and to notify the resident's medical doctor of any changes. A review of Resident 1's care plan titled Bruising. At risk for skin discolorations, bruising secondary to: (fragile skin, aging process, poor fluid/dietary intakes, antiplatelet therapy (drugs that prevent blood clots), locomotion impairment (reduced mobility in arms and legs) , cognitive impairment (dementia), initiated on 10/26/2023 indicated a goal to reduce the risk of skin discolorations and injury through appropriate interventions daily through the next assessment. Interventions included to administer medications as ordered, assess skin condition daily during care and with weekly body checks, and notify the medical doctor as indicated. A review of Resident 1's admission assessment, dated 2/19/2024, indicated Resident 1 was noted with bilateral (both) upper extremities (arm) bruising. A review of Resident 1's Physician Order, dated 2/19/2024, indicated an order of (Treatment) apply Cetaphil (hypo-allergenic, medication for skin allergy) lotion every four hours as needed for skin dryness / itchiness. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's Minimum Data Set (MDS, a comprehensive assessment tool), dated 4/29/2024, indicated Resident 1 had moderate cognitive impairment. The MDS indicated Resident 1 did not exhibit behaviors of hitting or scratching on self (Under Section E0200). The MDS indicated Resident 1 needed setup or clean up assistance with eating and staff supervision with oral hygiene, toileting hygiene, shower, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. The MDS also indicated Resident 1 has a diagnosis of diabetes mellitus and had no pressure injury (localized damage to the skin and underlying soft tissue, usually occurring over a bony prominence or related to medical devices), venous ulcer (wounds that occur when the veins in the legs do not push blood back up to the heart as well as they should), arterial ulcer (a painful, deep sore or wound in the skin of the lower leg or foot) or other skin problems. A review of Resident 1's Weekly Skin Report for May 2024 indicated Resident 1 did not have a pressure ulcer, vascular ulcer (wounds on the skin that develop because of problems with blood circulation), diabetic ulcer (open wound or sore that can be difficult to heal), or other acquired skin conditions in the first week of May 2024. A review of Resident 1's Documentation Survey Report for May 2024, indicated Resident 1 received a shower on Thursday (5/9/2024) by Certified Nursing Assistant 2 (CNA 2) and on Saturday (5/11/2024) by CNA 1. A review of Resident 1's Change of condition / Interact Assessment Form (COC Form), dated 5/12/2024 at 12:04 pm, indicated Resident 1 was identified with left upper extremity fluid filled blisters. The COC form indicated 1200 (12:00 pm): CNA was assisting resident to dining room for lunch. While assisting resident CNA calls attention of charge nurse because resident has bumps on his hand. Charge nurse calls attention of RN (Registered Nurse) Supervisor for a full head to toe assessment. Upon head-to-toe assessment, Resident is noted with fluid filled blisters on left upper extremity. Cleansed site with Normal Saline (NS, a cleansing solution made up of water and salt), pat dry, and covered with rolled gauze until further orders from MD (Medical Doctor). All vital signs (measurements of the body's most basic functions such as body temperature, pulse rate, respiration rate and blood pressure) are within normal range, awaiting MDs (Medical Doctor) orders. Will continue to monitor as ordered and notify MD of any further changes / complications. 1215 (12:15 pm): Received new orders from MD as follows: 1) Left Upper Extremity; Cleanse with NS, pat dry, apply Xeroform (A petrolatum-based fine mesh gauze containing 3% bismuth tribromophenate [Medication that has antimicrobial properties]), then wrap with rolled gauze, diagnosis (DX): Fluid Filled Blisters. 2) Have resident seen and evaluated by wound consultant on 5/16/24 for further evaluation of treatment plan of care. All orders noted and carried out, will notify MD of any further changes / complications. A review of Resident 1's non-pressure sore skin problem report, dated 5/12/2024, indicated Resident 1 was identified with left upper extremity fluid filled blister (is a small pocket of fluid in the upper skin layers and is a common response to injury or friction) on 5/12/2024. A review of Resident 1's Physician Order, dated 5/12/2024 at 12:15 pm, indicated an order of [Treatment] Left Upper Extremity: Cleanse with NS (normal saline), pat dry, apply Xeroform then wrap with rolled gauze, every day shift for fluid filled blisters for 21 days. A review of Resident 1's Physician Order, dated 5/12/2024 at 12:15 pm, indicated an order to change dressing as needed when soiled or pulled out, monitor dressing integrity daily every day shift, monitor fluid filled blisters every day shift, and monitor for pain during treatment. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's Treatment Administration Record (TAR) for May 2024 indicated Resident 1 received wound treatments for his left arm on 5/12/2024, 5/13/2024 and 5/14/2024. A review of Resident 1's TAR for April and May 2024, indicated an as needed treatment order of Apply Cetaphil (Hypo-allergenic) lotion every four hours as needed for skin dryness / itchiness. The TAR indicated Resident 1 did not receive an as needed dose in April and May 2024. A review of Resident 1's Nurses Notes dated 5/12/2024 at 7:26 pm, 5/13/2024 at 4 am, 5/13/2024 at 1:07 pm, 5/13/2024 at 7:49 pm and 5/13/2024 at 11:28 pm, written by five different nurses (Licensed Vocational Nurse 2 (LVN 2), LVNs 3, 5, and 6 and Registered Nurse 2 (RN 2), indicated the same exact verbiage (statement) of Resident vital signs within in normal range. Awake. Alert and oriented times two with periods of confusion. Reality orientation provided. No acute distress noted. Skin is dry and warm to touch. Afebrile (no fever). On 72-hour monitoring for skin infection. No active bleeding. No verbalization of pain or any discomfort. Continue treatment as ordered. Maintained safety and hazard free environment. Call light within easy reach. All needs met and attended to promptly. Frequent visual check (by observing and looking using the eyes) rendered. Will continue to monitor. Notes on 5/13/2024 at 4 am, 5/13/2024 at 1:07 pm, 5/13/2024 at 7:49 pm and 5/13/2024 at 11:28 pm, had same statement/text f Resident on monitoring for skin infection Tx (treatment) ongoing tolerated well denies any pain or discomfort @ (at) this time. All needs met by staff call light win reach will continue to monitor for any changes. A review of Resident 1's Nurses Notes, dated 5/14/2024 at 3 am, indicated that Resident 1's Overall health status has been stable with no change in condition noted in the past week. A review of Resident 1's Change of Condition / Interact Assessment Form, dated 5/14/2024 at 9 am, indicated Resident 1 was identified of having behavior of refusing to eat, was stating he is very sad and does not want to be in the facility. The COC form also stated Resident 1 was noted picking on the blister on his skin despite it being wrapped with rolled gauze. A review of Resident 1's Physician Order, dated 5/14/2024 at 10 am, indicated an order to transfer Resident 1 to GACH 1 due to generalized weakness and variable food intake. A record review of Resident 1's GACH note titled ED Provider Assessment Note, dated 5/14/2024 at 1:19 pm by the emergency room Medical Doctor (EMRD), indicated Resident 1 arrived at the emergency department with Left upper extremity with maceration (A softening and breaking down of skin resulting from prolonged exposure to moisture) and ulceration (a break in the skin with loss of surface tissue) of the dorsal (back part) left forearm with erythema (redness) and induration (An area of hardness in the skin) circumferential with warmth and blistering extending up into the posterior shoulder. The ED Provider Assessment note indicated cefepime (Antibiotic), vancomycin (Antibiotic) and metronidazole (Antibiotic) were given based on empiric skin and soft tissue antibiotics (medication used to treat minor skin and soft-tissue infections) per infection disease recommendations for severe skin infection. The note indicated CT scan (A computed tomography scan is a medical imaging technique used to obtain detailed internal images of the body) was consistent with cellulitis. The note indicated that because of the severity of left upper extremity wound, general surgery recommended operating room for debridement but Resident 1's responsible party was not ready to make that decision at this time. ERMD 1's note indicated diagnoses of severe sepsis (a serious condition in which the body responds improperly to an infection), cellulitis, and urinary tract infection (An illness in any part of the urinary tract, the system of organs that makes urine). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A record review of Resident 1's GACH Integumentary (the body's outer layer which includes skin, hair, nails and glands) / Skin Wound note, date 5/14/2024 at 3:30 pm, indicated Resident 1 had left arm draining wound / cellulitis with two upper arm closed blood blister (a blister that is filled with blood instead of clear liquid). A review of Resident 1's CT of the left forearm without contrast (a substance taken by mouth or injected into an intravenous (IV) line that causes the particular organ or tissue under study to be seen more clearly) result from GACH 1, dated 5/14/2024 at 3:33 pm, indicated the reason for the CT scan was cellulitis and necrotizing soft-tissue infection (NSTI, diverse disease process characterized by extensive, rapidly progressive soft tissue inflammation and necrosis [cell death]). The impression of the scan indicated Findings compatible with known cellulitis. A review of Resident 1's CT of the left elbow without contrast result from GACH 1, dated 5/14/2024 at 3;33 pm, indicated the reason for the CT scan was cellulitis and NSTI. The impression of the scan indicated Findings compatible with cellulitis. A review of Resident 1's CT of the left humerus (upper arm bone) without contrast result from GACH 1, dated 5/14/2024 at 3:33 pm, indicated the reason for the CT scan of the humerus was cellulitis and NSTI. The impression of the scan indicated Findings compatible with known upper arm cellulitis. A record review of Resident 1's Surgery Consult Notes from GACH 1, dated 5/14/2024 at 5:51 pm, indicated, Upon further workup, patient became febrile (with fever) in the ED (emergency department) up to 100.5 with labs demonstrating severe leukocytosis (white blood cells in the blood are higher than normal which usually indicates an infection) up to 20.5 with a unit of measurement of 10 x 3 [NAME] (unit of measurement with normal range of 4 to 11; 10 x 3 [NAME] means thousands per cubic millimeter - a unit of measurement) in addition to positive UA (Urinalysis, a test of urine that identifies range of disorders such as urinary tract infection) and chronic (worsening) appearing left forearm wound with open drainage. General surgery consulted for further evaluation to rule out necrotizing skin infection. The surgery consult notes further indicated CT scans of L (left) humerus, elbow, and forearm obtained consistent with cellulitis. A review of Resident 1's care plan titled Blister, skin integrity impairment secondary to fluid filled blister to left upper extremity, created on 5/15/2024 by the MDSN (confirmed by Data History) but initiated on 5/12/2024 (backdated), indicated a goal to resolve the blister without complications through the next assessment. Interventions included to administer medications as ordered, apply pressure relief devices as appropriate and/or ordered, assess for causative factors that caused development and attempt to prevent recurrence, assess for s/s (signs and symptoms) of inflammation or infection i.e. Odor, pain, drainage, swelling, warm to touch, etc. and notify MD (medical doctor) as indicated / needed, assess skin condition daily during care and with weekly body checks, observe universal precautions (standard set of guidelines to reduce exposure to blood and body fluids through the use of protective barriers such as gloves, gown, masks and protective eyewear) while providing treatment, and provide treatment as ordered. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A review of the care plan titled Risk for infection. Resident is at: Moderate risk for infection secondary to: Fluid Filled Blister to LUE (left upper extremity), created on 5/15/2024 by the MDSN (confirmed by Data History) but initiated on 5/12/2024 (back-dated), indicated a goal to reduce the risk for Multidrug-Resistant Organisms (MDRO - group of bacteria that have become resistant to certain antibiotics so these antibiotics can no longer be used to control or kill the bacteria) transmission daily until the next assessment. Interventions included to administer antibiotics if ordered, monitor signs and symptoms of infection, notify medical doctor if any signs and symptoms of infections were observed, and perform wound care if indicated. During an interview on 5/16/2024 at 11:07 am, LVN 1 stated CNA 2 alerted him about Resident 1's arm which prompted him to go and see Resident 1 in the dining room on 5/12/2024. LVN 1 stated he observed Resident 1's left arm was full of blisters from his forearm up to his upper arm. LVN 1 stated the biggest blister he observed was about five inches by five inches and about 10 inches of the outer side of Resident 1's arm was covered with blisters. LVN 1 stated Not sure how he (Resident 1) got it. Looks like a burn. There's fluid in it. LVN 1 stated fluid was dripping from the blisters. LVN 1 also stated he observed RN 1 and Treatment Licensed Vocational Nurse 1 (TLVN 1) applied Betadine (Used on the skin to treat or prevent skin infection in minor cuts, scrapes, or burns) on the blisters and wrap the arm with gauze. LVN 1 did not provide any evidence of documentation regarding the sizes of the blisters observed in Resident 1. During an interview on 5/16/2024 at 11:36 am, RN 1 stated he was the Registered Nurse that assessed Resident 1 for his change of condition on 5/12/2024. RN 1 stated Resident 1 was observed with one to two small blisters on his left forearm that he (RN 1) described as fluid filled watery on top of the skin surface. RN 1 stated that the facility took a photo of Resident 1's arm to send to the wound specialist. RN 1 stated Two blisters, one is dime size and the other one is small than dime size. When asked if Resident 1's arm looked infected, RN 1 responded I would say it looked irritated. It is hard for me to say, I am not a wound infection expert, looks blisterous because of the fluid like it is possible infection. When asked why he thinks there is possible infection, RN 1 responded, Anything is possible infection just like all patients are fall risk and can fall, I say all wounds are also possibly infected. During an interview on 5/16/2024 at 12:05 pm, TLVN 1 stated and confirmed he was called by LVN 1 to look at Resident 1's left arm on 5/12/2024. TLVN 1 stated he observed Resident 1's left forearm with multiple blisters, with the biggest one measuring about 10 x 12 inches. TLVN 1 stated light brown fluid mixed with clear liquid was coming out of Resident 1's wound. TLVN 1 stated he noted discoloration around Resident 1's left forearm including redness around the blister. TLVN 1 stated Resident 1's wound was unusual as he has never seen anything like it before. TLVN 1 stated he asked Resident 1 what happened but Resident 1 doesn't remember how he got the blisters. TLVN 1 stated he cleaned the wound, patted it dry, applied Betadine and wrapped it with gauze prior to reporting the blisters to Wound Care Specialist Medical Doctor 1 (WCS 1). TLVN 1 stated he described the blister and drainage to Wound Care Specialist 1 (WCS 1) and he also sent a photo to her on 5/12/2024. TLVN 1 stated WCS 1 ordered to apply xeroform and to cover the arm with rolled gauze once a day. TLVN 1 stated he did not think Resident 1's forearm was infected because besides the drainage from the blister, Resident 1 did not have a fever and the area was not warm. TLVN 1 stated It was slight redness, not red as an infection. No Pain. If there was infection, would believe he would have pain. TLVN 1 stated that for wound infection, xeroform will not do much but an antibiotic would. No documentation evidence provided by the TLVN 1 regarding the sizes of the blisters and the description skin around the blisters. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/16/2024 at 12:36 pm, RN 2 stated she transferred Resident 1 on 5/14/2024 to GACH 1 due to his poor appetite and behavior of picking on his skin. RN 2 stated she saw Resident 1's left upper arm was red but not blistered anymore. RN 1 stated she observed the arm red and drying. RN 2 stated It was also alarming it was red, so I referred to the doctor. RN 2 stated Resident 1 was picking his skin. During an interview on 5/16/2024 at 1:06 pm, CNA 1 stated she showered Resident 1 on 5/11/2024 (Saturday) and noticed Resident 1 had a bandage, described as white, rectangle and taped, on one arm, but cannot recall which arm. CNA 1 stated the gauze had brown drainage just in the corner of the gauze and redness around the dressing. CNA 1 stated this is the first time she noticed Resident 1's arm like this. CNA 1 stated Resident 1 gets showers every other day except Sundays. CNA 1 stated Resident 1 complained of pain in his legs and arms. CNA 1 stated that she did not know what was under the dressing and she figured it was already reported since there was a dressing. During an interview on 5/16/2024 at 1:40 pm, CNA 2 stated the last time she took care of Resident 1 was on 5/12/2024 and on 5/9/2024 (Thursday). CNA 2 stated that on 5/9/2024 she gave Resident 1 a shower where she observed him with a skin tear on his left arm. CNA 2 stated she informed LVN 1 on 5/9/2024 of Resident 1's skin tear. CNA 2 further stated the same area where Resident 1 had the skin tear on 5/9/2024 was the same area she saw him with blisters on 5/12/2024. CNA 2 further stated I didn't notice until close to lunch (on 5/12/2024), he was scratching a little bit on his arm. I noticed he had blister on his skin. He took off his jacket and noticed full of redness and blisters. He has a lot of discoloration before, but these blisters were new. CNA 2 further stated the blisters looked infected and nasty with lots of drainage that looked like pus (Thick fluid caused by infection that includes white blood cells and cellular debris). His room usually smells but it smelled bad that day. CNA 2 stated she informed LVN 1 regarding the observation on 5/12/2024. During a follow up interview on 5/16/2024 at 2:04 pm, LVN 1 stated he did not see Resident 1 with a skin tear prior to 5/12/2024. During a follow up interview on 5/16/20224 at 2:33 pm, TLVN 1 stated Resident 1's wound had slight redness and brown drainage. TLVN 1 stated he relayed the observed redness and brown drainage to Wound Care Specialist 1 (WCS 1) on 5/12/2024. TLVN 1 stated that although the change of condition for Resident 1's wound was done on 5/12/2024 (Sunday), he did not do a care plan because Minimum Data Set (MDS) nurses do the care plans in the facility. TLVN 1 stated and confirmed MDS nurses are only in the facility on Mondays to Fridays. During an interview on 5/16/2024 at 2:49 pm, TLVN 2 stated he performed Resident 1's wound care treatment on 5/13/2024 and he observed Resident 1's forearm with a lot of blisters. TLVN 2 stated he followed the treatment order and cleaned the arm with normal saline, applied xeroform and wrapped the wound with kerlix. TLVN 2 stated Resident 1's wound was unusual because it was the first time, he has seen it. TLVN 2 stated Resident 1's blisters were oozing with brown fluid, and he assumed the blister popped because it was oozing. TLVN 2 further stated Resident 1 did not have any skin issues before. TLVN2 stated he did not report the changes to the attending physician. During an interview on 5/16/2024 at 3:06 pm, TLVN 3 described Resident 1's arm with yellowing and red and with serous drainage (a clear to yellow fluid that leaks out of a wound) when he saw the wound on 5/13/2024. TLVN 3 thought the redness on Resident 1's arm was due to irritation. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/16/2024 at 3:35 pm, TLVN 4 stated that on 5/10/2024, he was alerted by staff that Resident 1 was scratching his arm, so he washed Resident 1's arms, trimmed Resident 1's nails and put a patch of bordered dressing on Resident 1's upper arm. TLVN 4 stated there was no skin breakdown, but the skin was red. TLVN 4 stated he did not do a change of condition assessment and documentation on Resident 1's scratching because he did not observe any skin breakdown. TLVN 4 stated he placed a four-by-four gauze (4 inches by 4 inches medical fabric used in wound care) on the area to prevent skin breakdown. TLVN 4 stated he observed Resident 1's arm on 5/12/2024 with maybe three fluid filled blisters with the biggest size of 2.5 by 2.5 inches. TLVN 4 stated the blisters had no drainage on Sunday (5/12/2024). TLVN 4 stated that what he saw on Resident 1 on that Sunday was unusual because when a resident scratches, what appears is usually a tear and not a blister. TLVN 4 stated the following day, on 5/13/2024, he went to see Resident 1's left arm together with TLVN 2 where he observed redness with clear liquid coming out of the blister. TLVN 4 further stated it may be bolus pemphigoid (a rare skin condition that mainly affects older people. Starts with itchy, raised rash followed by blisters that forms on the skin) based on what TLVN 4 said. No documented evidence was provided by the TLVN 4 regarding the status of the blisters which include the size of the blister and the surrounding tissues for 5/12/2024 and 5/13/2024 as he described during the interview. During an interview on 5/16/2024 at 4:10 pm, CNA 3 stated she observed Resident 1 with a white bandage on his arm on 5/13/2024. CNA 3 stated Resident 1 informed her that he was not feeling good, so she informed LVN 3 and LVN 3 checked on Resident 1. During an interview on 5/16/2024 at 4:23 pm, CNA 4 stated that on 5/12/2024, he observed one of Resident 1's forearm with a bandage. CNA 4 stated he also observed the forearm with redness, so he informed LVN 2 and LVN 2 informed him Resident 1's arm was being treated for Cellitis (he means cellulitis). During an interview on 5/16/2024 at 4:45 pm, LVN 2 stated he observed Resident 1's left arm covered with gauze on 5/12/2024. LVN 2 stated he has observed Resident 1 scratch his skin before and Resident 1 stated he was itchy. During an interview on 5/16/2024 at 5:01 pm, the Director of Nursing (DON), stated she was made aware of Resident 1's blisters on 5/12/2024 on the telephone but she never saw Resident 1's arm on 5/12/2024. The DON stated she has never seen a patient with a blister in the arm. The DON stated she was informed Resident 1's skin is fragile, and Resident 1 always had discoloration on his arms. During an interview on 5/17/2024 at 1:49 pm, TLVN 5 stated that brown fluid inside a blister on 5/12/2024 would mean a mixture of blood and water. During an interview on 5/17/2024 at 2:05 pm, TLVN 4 stated Wound Care Specialist 1 said Resident 1's arm did not look infected based on the picture of the wound (photograph) sent by the facility to WCS 1. TLVN 4 stated the photograph (provided by the facility's administrator to the State Department) was the only photograph WCS 1 received. TLVN 4 confirmed and stated the photograph does not do what he observed justice because it does not show the blisters. TLVN 4 stated on 5/13/2024, together with TLVN 2, he observed drainage from the blister. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056237	A. Building B. Wing	05/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Terrace Convalescent Hospital	1240 S Hoover St Los Angeles, CA 90006

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a follow up interview on 5/17/2024 at 2:26 pm, CNA 3 identified and confirmed that the arm on the photograph was Resident 1's arm. CNA 3 stated that Resident 1 usually has dry skin and redness but not like the photograph. CNA 3 stated Resident 1's usual redness is more like sunburn redness. CNA 3 stated she has never seen Resident 1's arm this red before and it is not normal for Resident 1. CNA 3 stated if she sees a resident's arm like the photograph, she will report it immediately to the charge nurse. During a follow up interview on 5/17/2024 at 2:32 pm, TLVN 3 stated that on 5/13/2024, he observed Resident 1's arm with blisters that were open because there was drainage. TLVN 3 described the drainage as clear reddish describing it as serosanguinous (presence of both blood and the liquid part of blood). TLNV 3 stated Resident 1's arm had redness from the elbow area to the forearm, but he was not sure if the wound was infected. When asked if he wound have done anything differently, TLVN 3 stated he would have sent Resident 1 to the ER (emergency room) out of precaution because it could be something more serious. No documentation evidence provided by the TLVN 3 regarding the status of the blisters as he described during the interview. During a follow up interview on 5/17/2024 at 2:54 pm, LVN 1 stated he observed TLVN 1 clean the blisters of Resident 1 on 5/12/2024 with normal saline. LVN 1 stated he observed TLVN 1 squeeze the blister to clean out the drainage. LVN 1 stated the blister was probably open because it was dripping. LVN 1 stated he thought it was infected because it spread all over the arm. During an interview on 5/17/2024 at 3:42 pm, the WCS 1 stated she was informed by the treatment nurse (TLVN 1) that called her on 5/12/2024 that Resident 1 was noted with bruising a day or two before and was observed with lesions (an area in the skin that is abnormal compared to the surrounding skin) in the arm that looked like blisters. WCS 1 confirmed the facility sent her a photograph of Resident 1's arm on 5/12/2024. WCS 1 stated she wanted to do a video call with Resident 1 but Resident 1 refused. WCS 1 stated the facility never reported to her that there was drainage from the blister, so she did not think the blister was ruptured. WCS 1 stated she was not concerned of the redness because the treatment nurse explained to her about Resident 1's prior history of bruising so it may have been residual bruising and likely hyperpigmentation (patches of the skin are darker than the surrounding skin) or senile purpura (benign condition characterized by the recurrent formation of purple ecchymoses (bruises) on the exterior surfaces of forearms). WCS 1 stated she did not suspect cellulitis because to her knowledge, Resident 1 did not have diabetes or vascular disease. WCS 1 stated the facility did not inform her Resident 1 had diabetes. WCS 1 stated the facility did not report any drainage. WCS 1 further stated that if drainage was colored, she would have suspected infection and placed resident on prophylactic antibiotics (medications given to prevent infection). WCS 1 stated a brown drainage may suggest a murky drainage and any drainage that is murky is not good because it is bacteria making it that color. WCS 1 further stated if she had known that Resident 1 was diabetic, she may have treated him with prophylaxis Bactrim (an antibiotic). During a follow up interview on 5/17/2024 at 4:17 pm, the Director of Nursing (DON) stated the description of the wound in the change of condition assessment was not thorough because it failed to note how many blisters were present, what was the size of the blister, if there was any drainage or not and whether the blisters were intact or busted. The DON stated it is important to describe the wound in the change of condition assessment to help the doctor have more information in the chart. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review of the care plans titled Blister, skin integrity impairment secondary to fluid filled blister to left upper extremity and Risk for infection. Resident is at: Moderate risk for infection secondary to: Fluid filled blister to LUE, on 5/20/2024 at 2:27 pm, the Minimum Data Set Nurse (MDSN) stated he did not assess Resident 1 or Resident 1's wound. The MDSN stated and confirmed the two care plans were cr [TRUNCATED]