

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056243	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/17/2026
NAME OF PROVIDER OR SUPPLIER Western Slope Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3280 Washington Street Placerville, CA 95667	
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview, and record review, the facility failed to adequately assess, identify, monitor, and provide appropriate skin care and treatment for one of four sampled residents (Resident 1) when staff failed to recognize and address an ulcerated skin lesion on Resident 1's left wrist in a timely manner. This failure resulted that the wound became infested with multiple maggots and placed Resident 1 at risk for infection and worsening skin integrity. Findings: A review of Resident 1's admission record indicated the resident was admitted on 3/24 with diagnoses that included Alzheimer's disease (a progressive disease that causes memory loss and confusion) and a personal history of malignant skin cancer. A review of Resident 1's Minimum Data Set (MDS, a federally mandated assessment tool), dated 3/20/26, indicated a Brief Interview for Mental Status (BIMS) score of 4/15, which indicated the resident had severe cognitive impairment. A review of the Nurse's Note, dated 5/24/26 at 11:29 p.m. signed by Licensed Nurse (LN) 4, indicated that the nurse observed a soiled bandage on Resident 1's left wrist. When the nurse removed the bandage, she discovered a raised, ulcerated skin lesion measuring 2.5 cm (centimeter, a measurement, about 1 inch) x 2.5 cm. The Nurse's Note indicated that there were multiple active white tan larvae (maggots) moving inside the wound and the surrounding tissue. During an interview on 6/17/26 at 1:22 p.m. with LN 2, LN 2 stated that they did not perform daily skin assessments. LN 2 stated that CNAs informed the nurses when they noticed any skin issues of residents, and the nurses then reported the concerns to the treatment nurse. During an interview on 6/17/26 at 2:26 p.m., the Director of Nursing (DON) verified that, on 5/24/26, the evening nurse had called to inform him of Resident 1's wound infestation with maggots. During a phone interview on 6/22/26 at 1:57 p.m., the Medical Doctor (MD) stated the lesion was 100% a tumor. The MD explained that tumors did not appear overnight and that this one had likely been present for years. The MD stated the tumor could grow quickly or slowly, but it typically takes time to grow to that size. The MD also stated, Either somebody failed to check it, or they forgot to document it, and MD further stated that maggot infestation could occur at any time once a wound was open and exposed. A review of Resident 1's previous Nursing Weekly Summaries, dated 4/22/26, 5/13/26 and 5/20/26, signed by LN 1, indicated that Resident 1 had no identified skin impairment: No new skin issues this week. The Nursing Weekly Summaries contained no indication that the resident had refused skin assessments. Review of Resident 1's medical record, there was no documented evidence that the resident's skin lesion was identified, monitored and treated prior to 5/24/26. During a phone interview on 6/23/26 at 10:45 a.m. with LN 3, LN 3 confirmed that there was no documentation regarding Resident 1's wrist lesion prior to 5/24/26. During a phone interview on 6/23/26 at 11:32 a.m. with LN 1, LN 1 stated the Nursing Weekly Summary was based only on what she could observe. LN 1 stated that she could not complete a thorough skin check on Resident 1 during the night shift when she performed the skin assessment for the weeks of 4/22/26, 5/13/26 and 5/20/26. LN 1 explained that Resident 1 did not allow her to remove clothing at night because the resident always felt cold. LN 1 further stated that the only time her left wrist was checked was during the morning medication pass. During a phone interview on 6/23/26 at 12:16 p.m. with the DON, the DON stated that night shift nurses were expected to complete a thorough skin assessment when completing the Weekly Summary before residents went to sleep. The DON stated that although (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
--	-------	-----------

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056243	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/17/2026
NAME OF PROVIDER OR SUPPLIER Western Slope Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3280 Washington Street Placerville, CA 95667	
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	performing a thorough skin check during night shift could be difficult, the assessment was still required. If a resident refused, staff were expected to document the refusal. The DON further stated that nurses needed to complete a full, thorough assessment; otherwise, they should not have documented that the skin was intact. During a phone interview on 6/23/26 at 7:26 p.m. with LN 4, LN 4 stated that during her medication pass on 5/24/26 between 8:00 p.m. and 8:30 p.m., she noticed a skin tear and a soiled, undated bandage on Resident 1's left forearm. LN 4 stated that it was a common bandage that could be purchased anywhere. When she removed the bandage, she was very surprised to see the larvae and the wound. LN 4 also stated in her opinion, the lesion had not developed overnight given its size. According to the peer-reviewed article published on 5/31/24, in Proceedings of the Baylor University Medical Center, titled Dermatological Guide for Primary Care Physicians: Full Body Skin Checks, Skin Cancer Detection, and Patient Education on Self Skin Checks and Sun Protection, <https://pmc.ncbi.nlm.nih.gov/articles/PMC11188824/>, retrieved on 6/23/26, indicated a full body skin examination required a systematic, head-to-toe inspection, including removal of clothing, careful visual assessment of all skin surfaces, and evaluation of any lesions for suspicious features. The article emphasized that individuals with a history of skin cancer required ongoing, comprehensive skin assessments to detect new or changing lesions early and stated that failing to perform a complete skin examination increased the risk of missed malignancies and delayed treatment. A review of the facility's policy and procedure (P&P) titled Charting and Documentation, dated 7/25, showed the P&P 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. Documentation must be legible, objective, factual, and free of personal opinions. Weekly summaries must include overall clinical status, progress toward care plan goals, and significant events during the week.		