

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056333	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024
NAME OF PROVIDER OR SUPPLIER Mountain View Conv Hosp		STREET ADDRESS, CITY, STATE, ZIP CODE 13333 Fenton Avenue Sylmar, CA 91342	

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)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>38552</p> <p>Based on interview and record review the facility failed to provide care consistent with professional standards of practice to prevent pressure ulcer/injury (an injury that breaks down the skin and underlying tissue) to one out of three sampled residents (Resident 1) by failing to develop and implement a resident-centered care plan addressing and assessing the resident's pressure injury risk assessment weekly for the first four weeks for Resident 1 who was admitted with a deep tissue injury (serious condition that affects the underlying layers of skin, muscle, and other soft tissues) in the sacral region (area at the base of the spine, near the hips).</p> <p>The deficient practices had the potential for development and worsening of pressure ulcers/injuries to Resident 1.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, it indicated the facility admitted the resident on 6/26/2024, with diagnoses including type 2 diabetes mellitus (a disease that occurs when the blood glucose, also called blood sugar, is too high), difficulty in walking, and pressure-induced deep tissue damage of sacral region.</p> <p>During a review of Resident 1's History and Physical (H&P), dated 6/28/2024, the H&P indicated the resident does not have the capacity to understand and make decisions.</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 7/2/2024, the MDS indicated the resident was cognitively intact and required supervision with 10 feet (unit of measure) ambulation, sit to stand, toilet transfer, chair/bed-to-chair transfer, and personal hygiene. The MDS indicated the resident's skin condition with one unstageable - deep tissue injury and identified the resident as at risk for developing pressure ulcers/injuries. The MDS indicated the resident was occasionally incontinent of urine and stool (feces).</p> <p>During a review of Resident 1's Order Summary Report, the report indicated an order for coccyx (tail bone) area pressure injury to cleanse with normal saline (sterile water), pat dry, apply Medihoney (medical wound aid gel dressing) gel then cover with bordered dressing every day shift and as needed for 30 days, dated 6/26/2024.</p> <p>(continued on next page)</p>

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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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 8/19/2024 at 11:48 a.m., with Treatment Nurse 1 (TX 1), Resident 1's Care Plan (CP) titled, Risk for unavoidable pressure ulcer or potential for pressure ulcer development related to pressure injury coccyx DTI and limited mobility, initiated on 7/2/2024 was reviewed. The CP indicated an intervention to assess/record/monitor wound healing and measure length, width, and depth where possible, assess and document status of wound perimeter. TX 1 stated the care plan should have indicated the frequency of wound assessment as weekly because treatment nurses should complete the skin assessment for pressure ulcer/injury wounds weekly during rounds with the wound doctor.</p> <p>During a concurrent interview and record review on 8/19/2024 at 12:10 p.m., with TX 1, Resident 1's Skin & Wound Evaluation forms and nursing progress notes were reviewed. TX 1 stated there was no documentation the weekly pressure ulcer evaluation for the week of 7/1/2024 and 7/8/2024 was completed. TX 1 stated if the weekly evaluation was not done, the treatment nurse or the charge nurse should have documented why it was not done.</p> <p>During an interview on 8/19/2024 at 12:12 p.m., TX 1 stated it is their facility's policy and procedure to reassess wounds weekly to determine if the wounds are improving or getting worse and notify the resident's physician if the wounds are getting worse. TX 1 stated if the reassessment is not done the resident's wound could potentially get worse which could result in infection and possibly death. TX 1 stated the weekly pressure ulcer wound assessments is a nursing intervention and does not need a physician order.</p> <p>During a concurrent interview and record review on 8/19/2024 at 2:41 p.m., with the Assistant Director of Nursing (ADON), the facility's policy and procedure titled, Pressure Injury Risk Assessment, was reviewed. The ADON stated the P&P indicated to repeat the risk assessment weekly for the first four weeks, if there is a significant change of condition, or as often as is required based on the resident's condition. The ADON stated Resident 1's pressure injury care plan should have indicated the frequency of assessment, which is weekly. The ADON stated weekly pressure ulcer wound assessment is done to monitor the progress of the wound and inform the doctor if the wound is not improving or not responding to the treatment.</p> <p>A review of the facility's policy and procedure (P&P) titled, Pressure Injury Risk Assessment, last reviewed on 10/18/2023, indicated the purpose of this procedure is to provide guidelines for the structured assessment and identification of residents at risk of developing new pressure injuries or worsening of existing pressure injuries. The guidelines indicated that once the assessment is conducted and risk factors are identified and characterized, a resident-centered care plan be created to address the modifiable risk factors for pressure injuries and to repeat the risk assessment weekly for the first four weeks, or as often as is required based on the resident's condition. The P&P indicated documentation should be recorded including the condition of the resident's skin (e.g. the size and location of any red or tender areas) and if the resident refused the treatment, the reason for refusal and the resident's response to the explanation of the risks of refusing the procedure, the benefits of accepting and available alternatives.</p>		