

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  11/27/2024
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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42311</b></p> <p>Based an interview and record review, the facility failed to ensure a resident received care consistent with professional standards of practice to prevent pressure ulcers (PU-a localized injury to the skin and or underlying tissue usually over a bony prominences as a result of pressure or pressure in combination with shear) for one of three sampled residents (Resident 1) by failing to assess Resident 1's skin and wound weekly.</p> <p>This deficient practice placed Resident 1 at risk for development of pressure ulcers and worsening of wound.</p> <p>Findings:</p> <p>During a record review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 8/14/2023, with diagnoses that included chronic respiratory failure (long term condition when not enough oxygen passes from your lungs to your blood), tracheostomy (a procedure where a hole is made at the front of the neck. A tube is inserted through the opening and into the windpipe to help you breathe) and essential hypertension (occurs when you have abnormally high blood pressure that's not the result of a medical condition).</p> <p>During a record review of Resident 1's History and Physical (H&amp;P), dated 10/24/2024, the H&amp;P indicated Resident 1 was not alert, disoriented (to be confused or lost, particularly about one's sense of time, place, or identity), nonverbal and had functional quadriplegia (a condition that causes a person to be completely immobile due to a severe disability or frailty from another medical condition).</p> <p>During a record review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 8/14/2024, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 required extensive assistance from staff for all activities of daily living (ADL-personal hygiene, bed mobility, dressing, and transfers). The MDS indicated Resident 1 was incontinent (unable to control) bowel and bladder functions. The MDS also indicated Resident 1 was at risk for developing pressure ulcers.</p> <p>During a record review of Resident 1's Surgical Consult, dated 10/29/2024, the Surgical Consult indicated Resident 1 was at risk for developing pressure ulcers due to limited mobility.</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 11/26/2024, at 10:17 a.m., with Treatment Nurse (TN), Resident 1's Skin and Wound Evaluation, dated 10/24/2024, and 11/4/2024 was reviewed. The Skin and Wound Evaluation, dated 10/24/2024, indicated Resident 1 had a surgical wound (a cut made in the skin during surgery, also known as an incision) stoma (a surgical opening in the abdomen that connects an internal organ to the outside of the body) in the right lower quadrant of abdomen that measured 0.9-centimeter (cm-unit of measurement) in length and 3.7 cm. in width with heavy serous (clear) drainage. The Skin and Wound Evaluation dated 11/4/2024, indicated Resident 1's right lower abdomen surgical stoma wound measured 1.7 cm in length and 2.7 cm. in width with heavy serous drainage. TN stated Skin and Wound Evaluation should have been done and documented weekly. TN stated on 10/31/2024, the Skin and Wound Evaluation was not done. TN stated there were no documented Skin and Wound Evaluation on 10/31/2024. TN stated the importance of weekly Skin and Wound Evaluation was to monitor if resident was responding to treatments and to find out if wound was improving or not.</p> <p>During an interview on 11/26/2024, at 10:46 a.m., with Registered nurse 1 (RN 1), RN 1 stated Resident 1 had a surgical wound and should be assess and documented weekly to check if the wound size is improving, if there were changes in color and amount of discharges (drain) and if there were any signs of infection.</p> <p>During an interview on 11/26/2024, at 11:47 a.m., with the Director of Nursing (DON), the DON stated skin and wound assessment should be done on admission and weekly.</p> <p>During a concurrent interview and record review on 11/27/2024, at 4:02 p.m., with the DON, facility's policy and procedure titled, Pressure Injury Risk assessment dated ,d+[DATE], and last reviewed on 9/25/2024, the PP indicated, I. The purpose of a pressure injury risk assessment is to identify all risk factors and then to determine which can be modified and which cannot, or which can be immediately addressed and which will take time to modify. Repeat the risk assessment weekly for the first four weeks, if there is a significant change in condition, or as often as is required based on the resident's condition. The following information should be recorded in the resident's medical record utilizing facility forms:</p> <ol style="list-style-type: none"> <li>1. The type of assessment(s) conducted.</li> <li>2. The date and time and type of skin care provided, if appropriate.</li> <li>4. Any change in the resident's condition, if identified.</li> <li>5. The condition of the resident's skin (the size and location of any red or tender areas), if identified.</li> <li>6. How the resident tolerated the procedure or his or her ability to participate in the procedure.</li> <li>7. Any problems or complaints made by the resident related to the procedure.</li> <li>8. 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. Document family and physician notification of refusal.</li> <li>9. Observations of anything unusual exhibited by the resident.</li> </ol> <p>(continued on next page)</p>		

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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>10. The signature and title (or initials) of the person recording the data.</p> <p>11. Initiation of a (pressure or non-pressure) form related to the type of alteration in skin if new skin alteration noted.</p> <p>12. Documentation in medical record addressing MD notification if new skin alteration noted with change of plan of care, if indicated.</p> <p>13. Documentation in medical record addressing family, guardian or resident notification if new skin alteration noted with change of plan of care, if indicated.</p> <p>The DON stated skin assessment should have been done and documented weekly.</p> <p>During a record review of facility's PP titled, Wound Care dated 2010, and last reviewed on 9/25/2024, the PP indicated, Documentation:</p> <p>The following information should be recorded in the resident's medical record.</p> <ol style="list-style-type: none"> <li>1. The type of wound care given.</li> <li>2. The date and time the wound care was given.</li> <li>3. The position in which the resident was placed.</li> <li>4. The name and title of the individual performing the wound care.</li> <li>5. Any change in the resident's condition.</li> <li>6. All assessment data (wound bed color, size, drainage, etcetera) obtained when inspecting the wound.</li> <li>7. How the resident tolerated the procedure.</li> <li>8. Any problems or complaints made by the resident related to the procedure.</li> <li>9. If the resident refused the treatment and the reason(s) why.</li> <li>10. The signature and title of the person recording the data.</li> </ol>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>42311</p> <p>Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), who was receiving heparin (an anticoagulant medication that helps prevent the formation of blood clots) was monitored for its side effects of bleeding.</p> <p>This deficient practice had the potential to place Resident 1 at increased risk for side effects including bleeding.</p> <p>Findings:</p> <p>During a record review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 8/14/2023, with diagnoses that included chronic respiratory failure (long term condition when not enough oxygen passes from your lungs to your blood), tracheostomy (a procedure where a hole is made at the front of the neck. A tube is inserted through the opening and into the windpipe to help you breathe) and essential hypertension (occurs when you have abnormally high blood pressure that's not the result of a medical condition).</p> <p>During a record review of Resident 1's History and Physical (H&amp;P), dated 10/24/2024, the H&amp;P indicated Resident 1 was not alert, disoriented (to be confused or lost, particularly about one's sense of time, place, or identity) and nonverbal.</p> <p>During a record review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 8/14/2024, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 required extensive assistance from staff for all activities of daily living (ADL-personal hygiene, bed mobility, dressing, and transfers).</p> <p>During a record review of Resident 1's Physician Order, dated 10/23/2024, the Physician Order indicated heparin sodium injection (the act of putting a liquid, especially a drug, into a person's body using a needle and a syringe) 5,000 units per milliliter (ml- unit of measurement), inject 5,000 units subcutaneously (beneath or under the skin) every eight hours for deep vein thrombosis (DVT-occurs when a blood clot forms in one or more of the deep veins in the body, usually in the legs) prophylaxis (an attempt to prevent disease).</p> <p>During a record review of Resident 1's Medication Administration Record (MAR), dated 10/2024, and 11/2024, the MAR indicated Resident 1 received heparin injection from 10/24/2024 to 11/13/2024.</p> <p>During a concurrent interview and record review on 11/26/2024, at 10:46 a.m., with Registered Nurse 1 (RN 1), Resident 1's Physician Order dated 10/23/2024, and MAR dated 10/2024, and 11/2024 was reviewed. RN 1 stated residents on heparin needed to be monitored for side effect of bleeding and documented in MAR. RN 1 stated there were no documented monitoring for the side effect of bleeding in Resident 1's MAR dated 10/2024, and 11/2024. RN 1 stated the importance of monitoring was to prevent bleeding tendency and prevent a decrease in hemoglobin (a protein in red blood cells that carries oxygen from the lungs to the body's tissues and organs and returns carbon dioxide to the lungs).</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/26/2024, at 11:47 a.m., with the Director of Nursing (DON), the DON stated residents on heparin, or any anticoagulant needed to be monitored for its side effect of bleeding.</p> <p>During a concurrent interview and record review on 11/27/2024 at 4:02 p.m., with the DON, facility's policy and procedure (PP) titled, Anticoagulant-Clinical Protocol, dated 11/2018, and last reviewed on 9/25/2024, the PP indicated, 5. The staff and physician will monitor for possible complications in individuals who are being anticoagulated and will manage related problems. a. If an individual on anticoagulation therapy shows signs of excessive bruising, hematuria (blood in urine), hemoptysis (coughing up blood), or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant. b. The physician will order measures to address any complications, including holding or discontinuing the anticoagulant as indicated. The DON stated monitoring for bleeding was part of their policy.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>42311</p> <p>Based on interview and record review, the facility failed to maintain accurate and complete medical record for one of three sampled residents (Resident 1).</p> <p>This deficient practice had the potential to cause confusion in care and the medical records containing inaccurate documentation and can result in the delay of delivery of care.</p> <p>Findings:</p> <p>During a record review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 8/14/2023, with diagnoses that included chronic respiratory failure (long term condition when not enough oxygen passes from your lungs to your blood), tracheostomy (a procedure where a hole is made at the front of the neck. A tube is inserted through the opening and into the windpipe to help you breathe) and essential hypertension (occurs when you have abnormally high blood pressure that's not the result of a medical condition).</p> <p>During a record review of Resident 1's History and Physical (H&amp;P), dated 10/24/2024, the H&amp;P indicated Resident 1 was disoriented (to be confused or lost, particularly about one's sense of time, place, or identity) and nonverbal.</p> <p>During a record review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 8/14/2024, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 required extensive assistance from staff for all activities of daily living (ADL-personal hygiene, bed mobility, dressing, and transfers).</p> <p>During a record review of Resident 1's Progress Notes, dated 11/11/2024, timed at 8:33 p.m., the Progress Notes indicated Resident 1 was transferred to General Acute Care Hospital (GACH) on 11/11/2024, at 8:20 p.m.</p> <p>During a record review of Resident 1's Medication Administration Record (MAR), dated 11/2024, the MAR indicated Resident 1's oxygen saturation (O2 sat- a measurement of how much oxygen the blood is carrying as a percentage) on 11/12/2024 at 8 p.m., was 98 percent.</p> <p>During a concurrent interview and record review on 11/26/2024, at 10:46 a.m., with Registered Nurse 1 (RN 1), Resident 1's MAR dated 11/2024 was reviewed. RN 1 stated Respiratory Therapist 1 (RT1) documented on the wrong date because Resident 1 was transferred to GACH on 11/11/2024. RN 1 stated the importance of accurate documentation was to show accurate and correct vital signs (measurements of the body's most basic functions, such as breathing rate, pulse, blood pressure, and body temperature) of residents.</p> <p>During an interview on 11/26/2024, at 11:47 a.m., with the Director of Nursing (DON), the DON stated it is the facility's policy to document accurately.</p> <p>(continued on next page)</p>		

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<p>F 0842</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 11/27/2024, at 4:02 p.m., with the DON, facility's policy and procedure (PP) titled, Charting and Documentation, dated 7/2017, and last reviewed on 9/25/2024, the PP 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 medical record should facilitate communication between the interdisciplinary team (IDT- brings together knowledge from different health care disciplines to help people receive the care they need regarding the resident's condition and response to care). 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. The DON stated documentation should be accurate.</p>		