STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056429	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Convalescent Hospital	7509 N Laurel Ave Fontana, CA 92336

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44262 Based on interview and record review, the facility failed to prevent one of three sampled residents (Resident 1), who was diabetic, obese, and immobile and at risk for skin breakdown develop pressure injuries (pressure on body prominence causes breakdown to tissue) as follows: a. Left heel, left great toe and 1st metatarsal developed a deep tissue injury (DTI). And right medial foot fluid blister. b. Acquired an open wound to left elbow and sacral (tailbone) c. No family notification of left elbow and sacral open wound and wound treatment. This failure had the potential to result in a clinically compromised resident, (Resident 1) to be placed at risk for unnecessary pain, infection and death due to wounds not being identified and treated to prevent progressing. Findings: During review of Residents 1's Admission Record (general demographics), the document indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included: myocardial infarction type 2 (heart attack), diabetes type 2 (body does not produce enough insulin, or resist insulin), hemiplegia and hemiparesis (partial paralysis on one side of body), hypertension (high blood pressure). During a record review of Resident 1's medical records, reviewed and verified the following with Assistant Director of Nursing (ADON): a. Admission Reassessment dated [DATE], wound sites: Abdomen (gastrostomy (gastrostomy tube-a tube surgically inserted through abdominal wall to administer medications and liquid nourishment), right inner arm discoloration, sacrococcyx (tailbone)(scar tissue). No other skin breakdown. b. Change of Condition (COC) dated May 25, 2024, 10:54, Multiple skin Conditions: Treatment nurse noted that resident had multiple skin conditions. As follows: 1 Right medial foot fluid filled bister 2. Left heel Deep Tissue Injury (DTI) 3x3 Unstageable full thickness or tissue loss depth unknown (UTD). 3. Left Great Toe (DTI 0.5x0.5xUTD. 4. Left 1stMetatarsal DTI 1.5x1.5 UTD. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Minimal harm or potential for actual harm Residents Affected - Few	c. COC dated July 03, 2024, at 1359, Noted with Left elbow trauma wound reopened and pressure injury to sacrum .treatment initiated as order .attempted to call daughter {name}, no answer and could not leave voicemail. Called son {name}, no answer and could not leave voice mail. (Family was not notified, no follow up notification noted in medical records). During an interview on December 12, 2024, with the Treatment Nurse (TXT Nurse), TXT nurse stated, When there is a new wound, we do a COC, we monitor for 3 days, update the careplan, call the doctor and family. I leave a voice message and call back number, if voice message full, I would continue to call the family. Resident 1 did develop the Sacrococcyx wound in facility, he was on the heavier side, and be pushed back when we tried to reposition him. He was not able to reposition himself. I can agree the family was not notified and we should have continued with follow up call to inform. During an interview on December 12, 2024, with the Assistant Director of Nursing (ADON), ADON states, Just based on the records reviewed, He did come in with no wounds and he did develop the wounds here. I can agree they should not have developed here. There is no note that the family was ever notified of wound on July 06, 2024, he was sent out July 10, 2024. He was getting wound care treatment on the new wounds. During an interview on December 12, 2024, with the Administrator (Admin), Admin states, Resident 1, I can agree he should not have developed any wounds, I am aware of the documentation. The family was called but there should have been follow through on the notification of new wounds and wound treatments we started. During a review of the facility's policy and procedure titled, Pressure Sore Management (no date), the policy and procedure indicated, All available measures shall be taken to reduce skin breakdown and pressure sores. During a review of the facility's policy and procedure titled, Prevention of Pressure Injuries revised March 2023, the policy and procedure indicated, The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific factors .Assess the resident on admission for existing pressure injury risk factors. Repeat the risk assessment weekly and upon any changes in condition .reposition all residents with or at risk for pressure injuries on an individualized schedule, as determined by the interdisciplinary team .evaluate, report and document potential changes in the skin, review the interventions and strategies for effective ness on an ongoing basis. During a review of the facility's policy and procedure titled, Change in a Resident's Condition or Status revised (February 2021), the policy and procedure indicated, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and or status (e.g., changes in level of care .).