STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555030	A. Building B. Wing	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
College Vista Post-Acute	4681 Eagle Rock Blvd. Los Angeles, CA 90041

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. 46779 Based on interview and record review, the facility failed to assess and provide necessary wound care according to the physician's order for one of three sampled resident (Resident 1) by failing to ensure: 1. The Treatment Nurse (TXN) failed to assess Resident 1's surgical incision at the right hip with staples (a medical tool used to close wounds by joining the edges of skin together that are often used for deep wounds) and did not provide wound care to Resident's right hip as ordered by the physician's order since 8/14/24. 2. Assess and provide wound care on the left shin and perineal area due to MASD (moisture related skin damage) for Resident 1 on 8/1/24, 8/4/24, 8/18/24 and 8/19/24 (total 4 days). 3. The TXN conducted a thorough assessment and document weekly the skin condition for Resident 1 4. The licensed nurse assessed Resident 1's skin condition and documented accurately in Resident 1's nursing progress notes the treatments provided on 8/22/24 and 8/23/24. These deficient practices resulted in Resident 1 not receiving the needed wound care after surgery and was discharged from the facility to home located out of the state with 14 staples on the right hip that could result in increased pain and infection. In addition, the wound on the left shin and the MASD could worsened and result in higher level of care due to pain and infection. Findings: During a review of Resident 1's Admission Record indicated the facility admitted Resident 1 on 7/23/24 with diagnoses that include displaced fracture of greater trochanter of right femur (right hip fracture) and hyperlipidemia (a condition where there are high levels of fats in the blood). (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. During a review of a Minimum Data Set (MDS, a standardized assessment and care planning screening tool), dated 7/30/24, indicated Resident 1 had moderately impaired cognitive (ability to understand and make decisions) skills for daily decision making. The MDS indicated Resident 1 required setup or clean-up assistance with eating, supervision or touching assistance with oral hygiene and personal hygiene, partial/moderate assistance with upper body dressing, substantial/maximal assistance with roll left and right, sit to lying, lying to sitting on side of bed, and, and dependent with toileting hygiene, shower/bathe self, and lower body dressing and putting on/taking off footwear. MDS indicated Resident 1 required surgical wound care. During a review of Resident 1's Order Recap Reports, (summary of the physician's order) dated from 7/23/24 to 7/31/24 and from 8/1/24 and 8/31/24, indicated physician ordered: a. For the laceration (deep cut) wound at left shin: cleanse with normal saline (NS), pat dry, apply xeroform dressing (a sterile, non-adhering protective dressing), cover with dry dressing and wrap with rolled gauze daily and as needed. b. Moist Associated Skin Damage (MASD, an erosion or inflammation of the skin caused by long-term exposure to moisture) at perineal (the area of skin between the genitals and anus) extending to perianal area (the skin that surrounds the anus): cleanse with soap and water, pat dry, apply nystatin powder (a medication to treat fungal or yeast infections of the skin), leave open to air daily and as needed. c. Surgical wound at right hip: cleanse with NS, pat dry, apply betadine solution (a solution was used as a defense against bacteria, fungi, yeasts and viruses), cover with dry dressing daily and as needed. d. Surgical wound at right lateral (outer) thigh as needed and every day shift monitor the Aquacel dressing (a dressing supports wound management by helping skin to heal from the inside out), do not remove the dressing, may reinforce if dislodged. During a review of Resident 1's Skin Only Evaluation, dated 7/24/24, indicated Resident 1 had a surgical wound on the right hip, that measured six centimeter (CM, a measuring unit) in length and one CM in width, with 16 staples. The Skin Only Evaluation also indicated Resident had a second surgical wound on the right lateral hip, which was covered with Aquacel dressing. During a review of Resident 1's Care Plan, dated 7/24/24, indicated Resident 1 had an actual impairment of skin integrity of the right hip and was continued at risk for skin breakdown related to surgical wound. The Care Plan indicated to administer treatments as ordered, monitor/document for side effects and effectiveness: Cleanse with NSS, pat dry, apply betadine solution, cover with dry dressing daily and as needed, and assess/record/monitor wound healing on a weekly basis and as needed. During a review of Resident 1's Post Discharge Plan of Care and Summary, dated 8/23/24, indicated Resident 1 did not have a skin issue and did not require wound care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/17/24 at 9:42 AM, with the Family Member (FM) 1, FM 1 stated Resident 1 was discharged from the facility with 14 staples on her right hip on 8/24/24. FM 1 stated she called the facility and the facility said Resident 1 did not have staples when she was discharged from the facility. FM 1 stated she took a picture of the staples and sent it to the facility, then, the facility told her to go to an urgent care to have the staples removed. FM 1 stated one of the staples was embedded (deeply attached) into Resident 1's skin and that caused pain when the doctor removed the staples in the hospital. FM 1 stated the paper discharge summary from the facility did not indicate that Resident 1 had staples on the hip and there was no instruction provided by the facility to the resident and FAM 1 on the care of the wound and follow up with a physician regarding the staple removal. 2. During a concurrent interview and record review on 9/17/24 at 12:07 PM, with the TXN, Resident 1's Treatment Administration Record (TAR), dated from 8/1/24 to 8/31/24, indicated there was no documentation that indicated wound care on the left shin and perineal extending to perianal area were provided on 8/1/24, 8/4/24, 8/18/24 and 8/19/24. The TAR also indicated no documentation that indicated wound care was provided on the right hip and right lateral thigh on 8/1/24 and 8/4/24. The TXN stated she and other licensed nurses that provided the wound care to Resident 1 should have documented in the TAR that wound care was provided as the proof that the wound care was done. The TXN stated she was not sure why the wound care was not documented on the TAR for these days. The TXN stated it was important to document on the TAR because no documentation meant it was not done. During a concurrent interview and record review on 9/17/24 at 12:15 PM, with the TXN, Resident 1's Nursing Progress Notes (NPN), dated 8/28/24, was reviewed. The NPN indicated Resident 1's staples on the right hip should have been removed on her last visit with the orthopedic surgeon (a medical specialist who focuses on injuries and diseases affecting the bones, muscles, joints) on 8/12/24, but the Nurse Practitioner (a nurse with advance clinical training) missed them. The TXN stated Resident 1 had two surgical incisions: one was at the right hip, and one was at right lateral thigh. The TXN stated there were staples on both incision sites. The TXN stated after Resident 1 returned from the orthopedic appointment in August 2024, she only checked Resident 1's surgical incision on the right lateral thigh and saw the staples and the Aquacel dressing were removed and covered with sterile strips and open to air. The TXN stated she did not check the surgical incision at the right hip because she assumed Resident 1's staples at right hip were also removed at the orthopedic appointment. The TXN stated she discontinued the wound care order on 8/14/24 and she did not provide wound care to the right hip as physician's order. The TXN stated she did not know Resident 1 still had the staples at the right hip after Resident 1 had been discharged until she read the NPN today. The TXN stated she should check Resident 1's skin thoroughly after the orthopedic appointment and continue to provide wound treatment as ordered to prevent wound infection. 3. During a concurrent interview and record review on 9/17/24 at 12:25 PM, with the TXN, Resident 1's Skin Only Evaluation, dated 7/24/24, was reviewed. The TXN stated she only completed one Skin Only Evaluation when Resident 1 was admitted . The TXN stated the weekly skin assessment should be completed by the TXNs or other designed licensed nurses. The TXN stated they probably forgot to follow up and complete the weekly skin assessment for Resident 1. The TXN stated it was important to do the weekly skin assessment because they could monitor and update Resident 1' skin condition effectively to prevent wound deterioration and infection. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. During a concurrent interview and record review on 9/17/24 at 1:28 PM, with the Licensed Vocational Nurse (LVN), Resident 1's Skin Only Evaluation, dated 7/24/24, and Nursing Progress Notes, dated 8/22/24 and 8/23/24, were reviewed. The LVN stated Resident 1 was assigned to her and she documented her assessment on NPN on 8/22/24 and 8/23/24. The LVN stated she did not assess and get updates from the Certified Nursing Assistants and the TXN regarding Resident 1's surgical incisions on the right hip and right lateral thigh. The LVN stated she copied the skin assessment notes from the previous NPNs and pasted on her NPNs for Resident 1 on 8/22/24 and 8/23/24. The LVN stated she did not know if the surgeon removed Resident 1's staples during her stay in the facility. The LVN stated she usually communicated with the TXN regard residents' skin condition if there was a change of condition (COC) Verbally. The LVN stated since there was no Change of Condition (COC) report regarding Resident 1's skin condition, she did not communicate with the TXN about Resident 1's wounds. The LVN stated she should assess Resident 1's skin and wound status herself to make sure her documentation was accurate instead of copying from the previous notes from other nurses. During an interview on 9/17/24 at 2:25 PM, with the Director of Nursing (DON), the DON stated the licensed nurses must document on the residents' TAR after they provided wound treatment to the residents. The DON stated if there was no documentation that meant the wound care was not done as indicated in the nursing standard of practice. The DON stated the TXN should assess Resident 1's skin thoroughly after she returned from the orthopedic appointment on 8/12/24 to make sure Resident 1's staples were removed. The DON stated the facility staff did not know Resident 1 still had staples on her right hip and did not provide would care to the right hip as the physician's order since 8/12/24. The DON stated the TXN should assess Resident 1's skin condition weekly and upon discharge from the facility and documented it to ensure Resident 1's wound was healing properly to prevent wound deterioration and infection. The DON stated the licensed nurses should not copy notes from the previous assessment notes from other nurses and documented it as their own assessment for the resident. The DON stated the licensed nurses should conduct their own assessment and document it in the nursing progress notes to ensure resident's condition was updated and the appropriate intervention was developed and implemented. During a review of the facility's P&P titled, Licensed Vocation Nurse-Job Descriptions, dated 2003, indicated LVN Prepare and administer medications as ordered by thy physician and Chart nurses' notes in an informative and descriptive manner that reflects the care provided to the resident. During a review of the facility's policy and procedure (P&P) titled, Documentation of Wound Treatment, dated 9/2/22, indicated the facility completes accurate documentation of wound assessments and treatments and Wound assessments are documented upon admission, weekly, and as needed. During a review of the facility's P&P titled, Skin Assessment, dated 12/19/22, indicated A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, and weekly thereafter.