STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555061	A. Building B. Wing	12/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Shepherd Health Care Center of Santa Monica	1131 Arizona Ave. Santa Monica, CA 90401

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observations, interviews, and record reviews, the facility failed to ensure that one out of three sampled residents (Resident 34) were free from physical restraint by failing to ensure the use of bilateral bed siderails consent was completed per individualized assessment. This deficient practice violated resident's right to be treated with respect and dignity with the use of restraints Cross Reference: F604 Findings: A review of Resident 34's admission record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic kidney disease (CKD-a longstanding disease of the kidneys leading to renal failure), pressure ulcer of sacral region (the triangular bone at the base of the spine that connects the spine to the pelvis) and pressure ulcer of left hip (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence). A review of Resident 34's Minimum Data Set (MDS - resident assessment tool) dated 9/28/2024, indicated Resident 34's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was moderately impaired. The MDS indicated Resident 34 required moderate assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During the initial tour of the facility and observation of Resident 34 on 12/27/2024 at 7:42 PM., Resident 34 was observed in bed, lying on a bed with a bilateral siderails up. During an interview with Resident 34's Family Member 2 (FM 2) on 12/28/2024 at 8:29 AM., FM 2 stated, Resident 34 had a previous fall incident and staff notified FM 2 bed side rails were added to Resident 34's bed to prevent the resident from falling. During an observation of Resident 34 on 12/28/2024 at 10:27 AM, Resident 34 was observed in bed, lying on a bed with a bilateral siderails up. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 34's Order Summary Report as of 12/29/2024, indicated there was no physician order for the use of bilateral bed siderails. A review of Resident 34's electronic and paper medical chart as of 12/29/2024 indicated, a Bed Side Rail for bed enabler and mobility was in the chart with no resident's name on the form and no date signed. During an interview with Certified Nursing Assistant 1 (CNA 1) on 12/28/2024 at 4:09 PM., CNA 1 stated, Resident 34 had bilateral bed side rails in the up position to prevent the resident from falling. CNA 1 stated Resident 34 was unable to hold on to the bed side rails or reposition herself. CNA 1 stated Resident 34 required assist to reposition. During an interview with CNA 4 on 12/29/2024 at 10:57 AM, CNA 4 stated Resident 34 had a history of falls and facility staff used the bed siderails to prevent the resident from rolling and falling off the bed. CNA 1 stated Resident 34 required assistance from staff for repositioning and did not have an upper extremity strength or hand use to hold on to the bed rails for repositioning. During an interview with Licensed Vocational Nurse (LVN 3) on 12/29/2024 at 10:53 AM, LVN 3 stated side rails were used for mobility and repositioning. LVN 3 stated, Resident 34 was unable to hold on to the bed rails and or self-reposition using the bed siderails. During a concurrent interview and record review with Medical Record Director on 12/29/2024 at 12:38 PM, MRD stated there was no consent form for the bed side rails in Resident 10's current chart but there was a consent form in Resident 10's old chart. MRD stated, the consent form was not complete as it did not have a resident's name and no date indicating when the consent was signed. During an interview with Director of Nursing (DON) on 12/29/2024 at 12:52 PM, DON stated the bed side rails were used for mobility and for repositioning. DON stated the bed side rails were not used to prevent residents from falling and bed side rails were considered a restraint if there was no physician's order and no consent on file. A review of the facility's policy and procedure (P&P) titled, Proper Use of Side Rails, dated 1/31/2024, the P&P indicated, The purposes of these guidelines are to ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medical symptoms . Consent for using restrictive devices will be obtained from the resident or legal representative per facility protocol. Consent for side rail use will be obtained from the resident or legal representative, after presenting potential benefits and risks.

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 43454 Based on observation, interview, and record review, the facility failed to ensure that one out of three sampled residents (Resident 34) were free from physical restraint by failing to ensure the physician's order for bilateral bed siderails was in placed and ensure the proper use of use rails according to facility's policy and procedure titled Proper Use of Side Rails, dated 1/31/2024. This deficient practice had the potential to result in entrapment and injury with the use of restraints. Cross Reference F552 Findings: A review of Resident 34's Admission Record indicated the facility originally admitted the resident on 1/4/2024 and readmitted the resident on 3/22/2024 with diagnoses including chronic kidney disease (CKD-a longstanding disease of the kidneys leading to renal failure), pressure ulcer of sacral region (the triangular bone at the base of the spine that connects the spine to the pelvis) and pressure ulcer of left hip (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence). A review of the Minimum Data Set (MDS - resident assessment tool) dated 9/28/2024, indicated Resident 34's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was moderately impaired. The MDS indicated Resident 34 required moderate assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During the initial tour of the facility and observation of Resident 34 on 12/27/2024 at 7:42 p.m., Resident 34 was observed in bed, lying on a bed with a bilateral siderails up. During an observation of Resident 34 on 12/28/2024 at 10:27 a.m., Resident 34 was observed in bed, lying on a bed with a bilateral siderails up. A review of Resident 34's Order Summary Report as of 12/29/2024, indicated there was no physician order for the use of bilateral bed siderails. During an interview with Certified Nursing Assistant 1 (CNA 1) on 12/28/2024 at 4:09 p.m., CNA 1 stated, Resident 34 had bilateral bed side rails up to prevent the resident from falling. CNA 1 stated, Resident 34 was unable to hold on to the bed side rails and move herself to reposition. CNA 1 stated, Resident 34 required staff assist to reposition. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Certified Nursing Assistant 4 (CNA 4) on 12/29/2024 at 10:57 a.m., CNA 4 stated, Resident 34 had history of falls and the facility used the bed siderails to prevent the resident from rolling and falling from the bed. CNA 4 stated, Resident 34 required assistance from staff for repositioning and did not have any upper extremity strength to hold on to the rail to reposition. During an interview with Licensed Vocational Nurse 3 (LVN 3) on 12/29/2024 at 10:53 a.m., LVN 3 stated, the side rails were used for mobility and repositioning. LVN 3 stated, Resident 34 was unable to use her hands to hold on to the rails and reposition herself using the bed siderails. During an interview with Director of Nursing (DON) on 12/29/2024 at 12:52 p.m., DON stated, the bed side rails were used for mobility and for repositioning. DON stated the bed side rails were not used to prevent residents from falling and bed side rails were considered a restraint if there were no physician's order and no consent on file. A review of the facility's policy and procedure (P&P) titled, Proper Use of Side Rails, dated 1/31/2024, the P&P indicated, The purposes of these guidelines are to ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medical symptoms . Side rails are considered a restraint when they are used to limit the resident's freedom of movement (prevent the resident from leaving his/her bed).

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on interviews and record reviews, the facility failed to implement their policy regarding reporting of an injury of unknown source in accordance with state or federal law for one of one sampled resident (Resident 34). This resulted in a delay of an onsite inspection by the Department of Public Health to ensure the residents' injury and accidents were investigated and had the potential to place residents at further risk for injuries. Findings: A review of Resident 34's admission record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic kidney disease (CKD-a longstanding disease of the kidneys leading to renal failure), pressure ulcer of sacral region (the triangular bone at the base of the spine that connects the spine to the pelvis) and pressure ulcer of left hip (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence). A review of the Minimum Data Set (MDS - resident assessment tool) dated 9/28/2024, indicated Resident 34's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was moderately impaired. The MDS indicated Resident 34 required moderate assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). A review of Resident 34's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) dated 11/12/2024, indicated a change of condition with nursing notes that stated, Resident (34) was found by Certified Nursing Assistant with lower extremity hanging from the side of bed with right knee touching the floor and resident holding onto siderails. No visible injury noted to the right knee, but the resident (Resident 34) has an open ecchymosis (a discoloration of the skin resulting from bleeding underneath, typically caused by a trauma) on her outer right arm. During an interview with Licensed Vocational Nurse 3 (LVN 3) on 12/28/2024 at 3:39 PM, LVN 3 stated Resident 34 was non-verbal, not able to turn independently and required assistance from staff with turning and repositioning. LVN 3 stated, Resident 34 was found hanging off the bed with an open ecchymosis on outer right arm, the incident was not witnessed by any staff or other residents. LVN 3 stated, Resident 34 was not able to verbalize and explain how she (resident 34) ended up on the floor. During an interview with Certified Nursing Assistant 1 (CNA 1) on 12/28/2024 at 4:09 PM., CNA 1 stated Resident 34 was unable to move independently and required staff assistance for repositioning. CNA 1 stated Resident 34 was also non-verbal and required staff assistance for feeding. CNA 1 stated Resident 34 had history of falling but CNA 1 did not know how Resident 34 could end up on the floor on her own as the resident did not have enough strength to move herself out of bed. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Director of Nursing (DON) on12/29/2024 at 12:55 PM, DON stated Resident 34 was not able to verbalize how she ended up dangling and on the floor. DON stated the incident was not witnessed by any staff and other residents. DON stated Resident 34 was hanging on the bed when found with an ecchymosis on her arm. DON stated the incident was not reported to the State Agency. A review of the facility policy and procedure (P&P) titled, Investigating Injuries, dated 1/31/2024, the P&P indicated, Injury of unknown source is defined as an injury that meets both of the following conditions: a. The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; and b. The injury is suspicious because of: (I) the extent of the injury; or (2) the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma). or (3) the number of injuries observed at one particular point in time: or (4) the incidence of injuries over time . The investigation will follow the protocols set forth in our facility's established abuse investigation guidelines. A review of the facility's P&& titled, Abuse and Prevention, dated 1/31/2024, the P&P indicated, Facility shall institute procedures of identifying unusual occurrences and events, such as suspicious bruising of residents, unexplained skin tears, fractures, etc. that may constitute abuse, Such procedural guidelines shall also provide for directions of necessary investigative efforts . Facility shall ensure thorough and extensive investigation of different types of incidents including by not limited to those that may constitute abuse. Facility shall ensure reporting of all alleged and/or substantiated violations to the state agency and all other agencies as required, and to take all necessary corrective actions based on the results of the investigation. Reporting: 1. Facility administrator shall be responsible for reporting of all alleged and substantiated violations to the state agency and all other agencies as required. 2. Facility shall report the incident by calling the DHS within 24 hours of the knowledge of such incident; followed by a letter explaining the circumstances surrounding the incident. This letter shall be maintained in a separate file and made available to the Department upon request. 3. The Administrator and Director of Nurses, in the order written, shall report (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incidents of suspected abuse to the following agencies within twenty-four (24) hours of occurrence: 3.1. Department of Public Health Licensing and Certification. 3.2. LTC Ombudsman or designee or. 3.3. Local enforcement agency or Police Department. 3.4. Managing Physician for treatment orders as required. 3.5. Family Members/Responsible Parties or Guardians 4. Facility Administrator shall report findings of investigation to the Department within five working days of the incident.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 44253 Based on observation, interview and record review, the facility failed to provide skin and pressure injury (injuries to the skin and underlying tissue, primarily caused by prolonged pressure on the skin) care consistent with professional standards of practice and facility policy and procedures for one of three residents (Resident 1), by failing to: a.Implement interventions to prevent Resident 1 from developing a stage 1 coccyx (tailbone) pressure injury. b.Create, implement, and update individualized interventions (specific care and services facility staff need to provide a resident to promote healing and prevent a worsening of a condition) to prevent Resident 1's coccyx stage 1 pressure injury discovered on 12/2/2024 from progressing to a stage 4 pressure injury (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) of the sacrum (Large triangle bone above the tailbone) and coccyx on 12/18/2024. c.Develop individualized resident-centered care plan (a plan of care that summarizes a resident's health conditions, specific care needs, and current treatments) interventions to address Resident 1's non-compliance with turning and activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily) care. These deficient practices resulted in Resident 1 developing a stage 1 pressure injury which progressed to a stage 4 pressure injury in 16 days, requiring debridement (medical removal of dead, damaged, or infected tissue to improve healing, removal may be surgical, mechanical, or chemical therapy) of the pressure injury. Findings: A. A review of Resident 1's Admission Record indicated the facility admitted the resident on 1/8/1998, with diagnoses including paraplegia (the inability to voluntarily move the lower parts of the body), polyneuropathy (when multiple peripheral nerves become damaged) and overactive bladder (sudden urges to urinate that may be hard to control). A review of Resident 1's at risk for skin breakdown injury care plan, initiated 10/16/2024, indicated the resident was at risk for skin breakdown due to non-compliance with turning and repositioning, and ADL care. A further review of the care plan indicated the goal was for the resident's risk of skin breakdown to be minimized and the resident would cooperate. The care plan interventions indicated staff were to: - provide care and reposition with care rounds. - clean Resident 1's skin after each episode of incontinence. - encourage independent turning. - provide activities that allow for skin improvement. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- provide education to resident, responsible party, and staff regarding special care. - provide pressure redistributing devices and assess for effectiveness. - provide skin care frequently. A further review of the care indicated there were no interventions to address what to do when the resident was non-compliant with turning and repositioning. A review of Resident 1's History and Physical (H&P), dated 11/11/2024, indicated Resident 1 had the capacity to understand and make decisions. The H&P indicated Resident 1 did not have any skin issues. A review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 11/19/2024, indicated the resident's cognition (ability to think, understand, and reason) was intact. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, supports trunk or limbs, but provides less than half the effort) with bed mobility, oral hygiene, showering, dressing and personal hygiene. The MDS also indicated Resident 1 was always incontinent, at risk for developing pressure sores, and did not have any pressure ulcers present at the time of the assessment (11/19/2024). A review of Resident 1's Braden Scale (pressure sore risk predictor tool) dated 11/19/2024, indicated Resident 1 had a Braden score of 16 which indicated the resident in the at-risk category to develop a pressure injury. A review of Resident 1's Progress Note, dated 12/2/2024, indicated the resident was on monitoring for sacrum non-blanchable redness (blood flow does not return to skin when pushed down). The note also indicated the resident was encouraged to turn and reposition with assistance and the resident was kept clean and dry. A review of Resident 1's stage 1 sacrum pressure injury, initiated 12/2/2024, indicated the goal was for the wound to show signs of improvement. The care plan interventions included to: - Educate the resident/representative on causes of skin breakdown including transfer/positioning, good nutrition, and frequent repositioning. - Encourage resident to frequently shift weight. - Evaluate skin for areas of blanching or redness. - Evaluate ulcer characteristics. - Keep skin clean and well lubricated. - Monitor bony prominences (areas where bones are close to the skin's surface, making them vulnerable to pressure) for redness. - Monitor nutritional status. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- Monitor ulcer for signs of progression or declination. - Notify provider if no signs of improvement on current wound regimen. - Provide wound care per treatment order. - Refer to specialized practitioner for wound management. A review of Resident 1's Physician Assistant (a licensed health professional who works with physicians to provide patient care) Wound Care Note, dated 12/4/2024, was the initial evaluation of the wound (2 days after the identification of a stage 1 by facility staff). The Note indicated the wound was a stage 2 wound and measured 3.2 centimeters (cm) x 2.1 cm width x 0.8 cm (length x width x depth). The Note indicated Resident 1 received skin/tissue debridement (removal of dead skin tissue to help a wound heal) performed by sharp selective debridement using a curette (a surgical instrument designed for debriding biological tissue) and #15 blade (a surgical scalpel). A review of Resident 1's Physician's Order, dated 12/4/2024, for a treatment of the stage 2 pressure injury on the coccyx, cleanse the area with normal saline (a saltwater solution), pat dry, apply Calmoseptine ointment (a topical medication used to protect and heal irritated or damaged skin) then cover with a bordered dressing every day until 1/4/2025. A review of Resident 1's stage 2 sacrum(coccyx) pressure injury care plan, initiated 12/4/2024, indicated the goal was for the wound to show signs of improvement. A review of the care plan indicated there were no updates to the care plan interventions. The care plan interventions included to: - Educate the resident/representative on causes of skin breakdown including transfer/positioning, good nutrition, and frequent repositioning - Encourage resident to frequently shift weight - Evaluate skin for areas of blanching or redness - Evaluate ulcer characteristics - Keep skin clean and well lubricated - Monitor bony prominences (areas where bones are close to the skin's surface, making them vulnerable to pressure) for redness - Monitor nutritional status - Monitor ulcer for signs of progression or declination - Notify provider if no signs of improvement on current wound regimen - Provide wound care per treatment order (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's Wound- Weekly Observation Tool dated 12/5/2024, indicated Resident 1 had acquired while at the facility a Stage 1 pressure ulcer on the coccyx (tail bone) that measured 3.2 centimeters (cm) x 2.1 cm x 0.8 cm. The Wound - Weekly Observation Tool also indicated the skin around the wound was macerated (skin is soft, soggy, or wet to the touch which occurs when the skin is in contact with moisture for too long). A review of Resident 1's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 12/11/2024, indicated Resident's coccyx stage 2 pressure injury worsened to a stage 3 (full-thickness loss of skin. Dead and black tissue may be visible). The SBAR indicated the resident was seen by wound physician assistant with new orders given. A review of Resident 1's Physician's Order, dated 12/11/2024, indicated an order for the treatment of the stage 3 coccyx pressure injury, cleanse the area with sodium hypochlorite 0.25% (antiseptic, used prior to surgical procedures or for minor wound care to reduce risk of infection), pat dry, apply Mupirocin 2% ointment (a topical antibiotic used to treat skin infections caused by bacteria) and Santyl (ointment used to remove damaged tissue from chronic skin ulcers and severely burned areas), then cover with dry dressing every day until 1/11/2025. A review of Resident 1's Nurse's Note, dated 12/11/2024, indicated the resident was on monitoring for coccyx stage 3 pressure injury. The note indicated the resident was kept clean and dry, turned, and repositioned every 2 hours. A review of Resident 1's stage 3 sacrum pressure injury, initiated 12/11/2024, indicated the goal was for the wound to show signs of improvement. A review of the care plan indicated there were no updates to the care plan interventions. The care plan interventions included to: - Educate the resident/representative on causes of skin breakdown including transfer/positioning, good nutrition, and frequent repositioning - Encourage resident to frequently shift weight - Evaluate skin for areas of blanching or redness - Evaluate ulcer characteristics - Keep skin clean and well lubricated - Monitor bony prominences (areas where bones are close to the skin's surface, making them vulnerable to pressure) for redness - Monitor nutritional status - Monitor ulcer for signs of progression or declination - Notify provider if no signs of improvement on current wound regimen - Provide wound care per treatment order (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- Refer to specialized practitioner for wound management A review of Resident 1's Wound- Weekly Observation Tool dated 12/12/2024 (one week later), indicated Resident 1's coccyx pressure ulcer was originally a stage 2 (Partial-thickness loss of skin, presenting as a shallow open sore or wound) and was a stage 3 (Partial-thickness loss of skin, presenting as a shallow open sore or wound) on the date of assessment (12/12/2024). The Wound Observation Tool indicated the wound was worsening. And the skin was devitalized (skin that is weak or no longer living, often due to injury or disease). The Wound Observation Tool indicated Resident 1's coccyx pressure injury measured 3.5 cm x 2.5 cm x 1 cm (an increase in size in length, width, and depth). A review of Resident 1's Nurse's Note, dated 12/13/2024, indicated the resident refused to be changed every hour. The Note further indicated the resident remained in the wheelchair does not want to be transferred into bed to get changed. The nurse explained the risks and benefits and the resident still refused. A review of Resident 1's Physician Assistant Wound Progress Note, dated 12/18/2024, indicated Resident 1 had a stage 4 pressure ulcer with necrosis of muscle and necrosis of bone. The Progress indicated the wound's healing status was declining. The note further indicated the wound underwent debridement and the type of tissue removed was necrotic subcutaneous tissue, devitalized subcutaneous tissue and necrotic muscle. A review of Resident 1's SBAR, dated 12/18/2024, indicated Resident 1's coccyx stage 3 pressure injury worsened to a stage 4. The SBAR indicated the resident was seen by a wound physician assistant with new orders given and carried out. The SBAR indicated the resident was medicated with Tylenol 650 mg 30 minutes prior to wound care. A review of Resident 1's Nurse's Note, dated 12/18/2024 timed at 6:29 PM, indicated the resident was on monitoring for a coccyx stage 4 pressure injury. The note indicated Resident 1 was turned and reposition every 2 hours. A review of Resident 1's stage 4 sacrum pressure injury care plan, initiated 12/18/2024, indicated the goal was for the wound to show signs of improvement. A review of the care plan indicated there were no updates to the care plan interventions. The care plan interventions included to: - Educate the resident/representative on causes of skin breakdown including transfer/positioning, good nutrition, and frequent repositioning - Encourage resident to frequently shift weight - Evaluate skin for areas of blanching or redness - Evaluate ulcer characteristics - Keep skin clean and well lubricated - Monitor bony prominences (areas where bones are close to the skin's surface, making them vulnerable to pressure) for redness (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555061	A. Building B. Wing	12/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Shepherd Health Care Center of Santa Monica	1131 Arizona Ave. Santa Monica, CA 90401

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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 0686 Level of Harm - Actual harm Residents Affected - Few	- Monitor nutritional status - Monitor ulcer for signs of progression or declination - Notify provider if no signs of improvement on current wound regimen - Provide wound care per treatment order - Refer to specialized practitioner for wound management A review of Resident 1's Wound- Weekly Observation Tool dated 12/19/2024 (two weeks after the initial assessment), indicated Resident 1's coccyx pressure ulcer was a Stage 4. The Wound Observation Tool indicated the wound went from a stage 4 from a stage 3 and measured 4.1 cm x 3.5 cm x 1 cm (an increase in length and width. A review of Resident 1's Physician's Order, dated 12/19/2024, for the treatment of the stage 4 pressure injury on the coccyx, cleanse the area with Dakins 0.25% solution (an antiseptic first aid cleaning solution for wounds), pat dry, apply Mupirocin ointment and Santyl, then cover with dry dressing every day for 30 days. A review of Resident 1's Nurse's Note, dated 12/22/2024, indicated the resident refused to be turned and repositioned during the shift. The Nurse's Note further indicated the nurse explained the risks and benefits, but the resident stated they were comfortable in their position. During an observation in Resident 1's room with Licensed Vocational Nurse 3 (LVN 3), on 12/28/2024 at 2:25 PM, Resident 1's wound care was observed. During the observation Resident 1 was noted with a Sacro-coccyx (wound over the sacrum and coccyx) pressure sore that was open, deep, and the skin surrounding the wound was red and macerated. During the wound care Resident 1 yelled out in pain. During an interview on 12/29/2024 at 10:28 AM, LVN 3 stated Resident 1 did not have a pressure ulcer on admission. LVN 3 stated on 12/2/2024, Resident 1 was noticed to have non blanchable redness on the sacrum, which then became a stage 2 and then became a stage 3 on 12/11/2024, nine days after the wound was initially found. During a concurrent record review of Resident 1's pressure ulcer care plans were reviewed. LVN 3 stated Resident 1's stage 1, stage 2, stage 3 and stage 4 coccyx pressure injury care plans interventions were all the same. LVN 3 stated care plans were to be updated with new interventions when previous interventions are not effective. LVN 3 stated a possible outcome from not revising the interventions was that Resident 1's wound could worsen. LVN 3 stated Resident 1's wound had progressed due to the resident refusing to turn every 2 hours. During a concurrent record review of Resident 1's noncompliance with turning care plan, 12/29/2024 at 10:28 AM, LVN 3 stated the care plan did not have individualized interventions to address the resident not turning. LVN 3 stated the care plan interventions could have included notifying the charge nurse or Resident 1's family member so they could attempt to convince the resident to turn. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555061	A. Building B. Wing	12/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Shepherd Health Care Center of Santa Monica	1131 Arizona Ave. Santa Monica, CA 90401

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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 0686 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 12/29/2024 at 1:34 PM, the Director of Nursing (DON) stated Resident 1 was at increased risk for developing a pressure ulcer due to the resident's weight loss, so the facility provided the resident with a low air loss mattress (LALM-a mattress designed to prevent and treat pressure wounds) in October 2024. The DON stated Resident 1 was noncompliant with turning. The DON reviewed Resident 1's pressure ulcer care plans, the DON stated the care plans were all similar. The DON stated care plans were to be individualized and person centered to effectively care for resident's problems and the care plan had to be updated when the interventions were not effective. A review of the facility's policy and procedure (P&P) titled, Prevention of Pressure Injuries, reviewed 1/31/2024, indicated staff were to review the resident's care plan identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable and review the interventions and strategies for effectiveness on an ongoing basis. A review of the facility's P&P, Care Plans, Comprehensive Person-Centered, reviewed 1/31/2024, indicated a comprehensive care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs was to be developed and implemented for each resident. The care planning process will include an assessment of the resident's strengths and needs, incorporate the resident's personal and cultural preferences in developing the goals of care. The P&P further indicated assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change.