STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555214	A. Building B. Wing	02/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Professional Post Acute Center	81 Professional Center Parkway San Rafael, CA 94903

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44968 Based on interviews and records review, the facility failed to ensure care plan conferences were conducted for two or two sampled residents (Residents 1 and 2). This failure resulted to Resident 1 ' s Representative and Resident 2 not being able to exercise their right to participate with care planning on continuing or changes in care, treatment, and healthcare goals that could affect Resident 1 and Resident 2 ' s quality of care and quality of life. Findings: Resident 1 During an interview with Witness C on 12/20/23 at 1:26 p.m., Witness C stated Resident 1 had no capacity to make healthcare decisions due to Dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). He stated he expected the facility to invite him every scheduled care plan meetings as he was Resident 1 ' s Representative to make healthcare decisions and would not miss any of the care plan meetings if he was invited; however, he stated he was not invited to participate with most of the care plan meetings. Witness C also stated most of the meetings were not a multidisciplinary team (a mix of healthcare professionals come together to plan and coordinate resident ' s care) care conference. He stated a social worker designee facilitates the care plan meetings and there was no clinically trained staff who could answer clinical related questions. During a review of the Face sheet (A one-page summary of important information about a resident) indicated Resident 1 was admitted on [DATE] with diagnosis including but not limited to: Diabetes Mellitus (disease that result in too much sugar in the blood); Hypertension (High Blood Pressure); and Neurocognitive Disorder (decreased mental function due to a medical disease other than a psychiatric [relating to mental] illness). During a review of the Minimum Data Set (MDS - an assessment tool completed by clinical staff to identify potential resident problems, strengths, and preferences) dated 9/29/23 indicated Resident 1 had a short and long term memory problem. Her cognitive (relating to the mental process involved in knowing, learning, and understanding things) skills for daily decision making was severely impaired. (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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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the document titled Multidisciplinary Care Conference dated 4/04/23 at 2:42 p.m. indicated a quarterly care conference was held with the following attendees: Nursing, Dietary Manager, Therapy, Social Service and Activities. The document indicated a conference notification was sent to Resident 1 ' s Representative via telephone call; however, the document indicated Resident 1 ' s Representative did not attend or participate with the care conference. During an interview and concurrent record review with the Social Service Director (SSD) on 2/15/24 at 11:51 a.m., the SSD stated care conferences are held every quarter and as needed to address any change of condition. The SSD stated she was responsible for coordinating with the Interdisciplinary Team (IDT - group of health care professionals who work together toward the goals of the resident) and responsible for sending the invitation to the residents or their representatives in person or via phone call one week prior to the scheduled meeting. She stated if resident ' s representative were not available on the set date, she stated she would move the care conference to accommodate the representative. After review of the electronic record for Resident 1, the SSD stated Resident 1 had a care conference on 7/13/20, 9/23/21, 7/27/22, 10/13/22 and 4/4/23. The SSD stated she did not know the reason why Resident 1 did not have a care conference every three months. She stated she started her employment on January 2024. Resident 2 During a review of the Face sheet indicated Resident 2 was admitted on [DATE] with diagnosis including but not limited to: Paraplegia (paralysis of the legs and lower body) and Major Depressive Disorder (a mental disorder characterized by a persistently depressed mood and long-term loss of pleasure or interest in life). During review of the MDS dated [DATE] indicated Resident 2 had a BIMS score of 15 out of 15 (Brief Interview for Mental Status - a 15-point cognitive screening measure that evaluates memory and orientation. A score of 13 - 15 is cognitively intact, 08 - 12 is moderately impaired, and 00 - 07 is severe impairment). During a review of the electronic record for Resident 2 with the SSD, the SSD verified Resident 2 had a care conference held on 3/21/23 and 11/09/23. Review of the Facility policy and procedure titled Care Plans, Comprehensive Person-Centered revised on March 2022 indicated: The resident is informed of his or her right to participate in his or her treatment and provided advance notice of care planning conferences; The policy indicated, If the participation of the resident and his/her resident representative in developing the resident's care plan is determined to not be practicable, an explanation is documented in the resident's medical record. The explanation should include what steps were taken to include the resident or representative in the process. The policy indicated the IDT reviews and updates the care plan when: - There has been a significant change in the resident's condition; - The desired outcome is not met; - The resident has been readmitted to the facility from a hospital stay; and - At least quarterly, in conjunction with the required quarterly MDS assessment.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44968 Based on interviews and records review, the facility failed to implement timely revision of ADL (Activities of Daily Living) Self Care Performance Deficit Care Plan for one of two residents (Resident 1) when the facility did not update the Care Plan for Resident 1 reflecting the decline in Resident 1 ' s functional status. These failure had the potential for facility staff to provide inadequate care and supervision to ensure Resident 1 ' s health and safety needs. (Reference F689, F686) Findings: During a review of the Face sheet (A one-page summary of important information about a resident) indicated Resident 1 was admitted on [DATE] with diagnosis including but not limited to: Diabetes Mellitus (disease that result in too much sugar in the blood); Hypertension (High Blood Pressure); and Neurocognitive Disorder (decreased mental function due to a medical disease other than a psychiatric [relating to mental] illness). During a review of the document titled Post-Fall Review dated 10/21/23 indicated Resident 1 was found lying at the hallway on 10/21/23 at 7:00 p.m. The document indicated Resident 1 was last observed lying in bed/sleeping prior to the fall. During a review of the Progress Note dated 11/22/23 at 7:49 p.m. indicated Resident 1 was noted with 4.5 cm (centimeter- a metric unit of length) x (by) 4.5 cm non-blanchable redness (skin redness that do not fade when a person presses on them) to sacrococcyx area (pertaining to both the sacrum and coccyx with an open wound measuring 0.5 cm x 0.7 cm. During a review of the Care Plan for ADL Self Care Performance Deficit Resident 1 initiated on 12/31/19 and concurrent interview with the MDS (Minimum Data Set - an assessment tool completed by clinical staff to identify potential resident problems, strengths, and preferences) Coordinator (a nursing professional who helps manage a nursing team in a medical facility) on 2/08/24 at 11:48 a.m., the Care Plan indicated Resident 1 was able to ambulate around facility without assistance or assistive device and able to move freely in bed; however, when the MDS Coordinator was asked how much ADL support did Resident 1 require with transfers, bed mobility and ambulation prior to her fall on 10/21/23, the MDS Coordinator stated Resident 1 ' s MDS dated [DATE] indicated Resident 1 required extensive one person physical assistance with transfers, bed mobility and ambulation. When the MDS Coordinator was asked who was responsible for updating the care plans, he stated he was responsible for updating long term care plans every quarter (three months). The MDS Coordinator concurred that Resident 1 ' s ADL care plan should have been updated to reflect Resident 1 ' s current functional status. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the Pressure Ulcer Care Plan for Resident 1 initiated on 11/22/23 and concurrent interview with the MDS Coordinator on 2/08/24 at 12:02 p.m. indicated Resident 1 had episodes of noncompliance with turning and repositioning. One of the Care Plan interventions indicated, Encourage to reposition self as tolerated. When the MDS Coordinator was asked if it was possible for Resident 1 to reposition herself to completely relieve her sacrum from pressure when she required extensive assist with bed mobility, he stated no. The MDS Coordinator verified there was no care plan for Resident 1 ' s noncompliance with turning and repositioning in bed prior to the identification of pressure ulcer. During a review of the Pressure Ulcer Care Plan for Resident 1 initiated on 11/22/23 and concurrent interview with the Director of Nursing (DON) on 2/08/23 at 1:53 p.m., the DON verified one of the care plan interventions indicated Encourage to reposition self as tolerated. When the DON was asked about her expectations for a care plan, the DON stated the care plan must reflect the actual care given to each individual residents and interventions must be updated as needed. Review of the Facility policy and procedure titled Care Plans, Comprehensive Person-Centered revised on March 2022 indicated, The comprehensive, person-centered care plan includes measurable objectives and timeframes; describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being The policy indicated the Interdisciplinary Team (IDT - group of health care professionals who work together toward the goals of the resident) reviews and updates the care plan when: There has been a significant change in the resident's condition; and At least quarterly, in conjunction with the required quarterly MDS assessment.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 44968 Based on observations, interviews and records review, the facility failed to meet nursing professional standards for one of two sampled residents (Resident 1) when a facility licensed staff provided wound treatment to Resident 1 without a physician ' s order. This failure had a potential risk for Resident 1 of adverse drug reaction. (Reference F686) Findings: During a review of the Progress Note dated 11/22/23 at 7:49 p.m. and concurrent interview with Licensed Staff B on 2/08/24 at 11:14 a.m., the progress note indicated Resident 1 was noted with 4.5 cm x 4.5 cm of non-blanchable redness (skin redness that do not fade when a person presses on them) to sacrococcyx area (pertaining to both the sacrum and coccyx) with an open wound measuring 0.5 cm x 0.7 cm., and was treated with Medihoney (a brand name wound and burn gel). When Licensed Staff B was asked if Resident 1 ' s physician gave the order to treat the wound with medihoney, Licensed Staff B stated yes; however, after review of the Physician ' s Order with Licensed Staff B, she stated there was no order written for medihoney on 11/22/23. She stated she got the order herself from the physician and could have forgotten to enter a physician ' s order. During a review and concurrent interview with the Director of Nursing (DON) on 2/08/24 at 1:35 p.m., the Progress Note dated 11/22/23 at 10:00 p.m. indicated Resident 1 ' s sacral wound was treated with Medihoney, however; after review of the Physician ' s order with the DON, the DON verified there was no written treatment order for Resident 1 ' s sacral wound on 11/22/23. When the DON was asked about her expectations form nurses when providing wound treatment to the residents, she stated, nurses cannot dispense any medication without a doctor ' s order. She stated she expected the nurses to obtain a doctor ' s order for any medication prior to medication or treatment administration following the five rights (right patient, right drug, right time, right dose, right route) of medication administration. During an interview with Licensed Staff F on 2/15/24 at 11:16 a.m. when Licensed Staff F was asked how are new skin issues identified for residents, she stated skin check was constantly done when providing resident care. Licensed Staff F stated if a new wound was observed, this will be document to the resident ' s medical record and will notify the physician to obtain treatment order. Licensed Staff F stated she could clean the wound and cover with dry dressing while waiting a for treatment order from the doctor. Review of the Facility policy and procedure titled Administering Medications revised on April 2019 indicated, Medications are administered in a safe and timely manner, and as prescribed.

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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** 44968 Based on interviews and records review, the facility failed to provide necessary services for one of two sampled residents (Resident 1) when: 1. The facility did not perform a rehabilitation screening for Resident 1 after the fall to evaluate any adverse effects from the fall and the potential need for rehabilitation services. 2. The facility waited for eight (8) days to perform a right hip X-ray (a type of medical imaging that creates pictures of the bones and soft tissues) after Resident 1 had complained of right hip pain and waited for another 8 days to obtain an order for weight bearing precaution after Resident 1 was found with right femoral fracture (a break in the thigh bone). These failure resulted to a delayed treatment and could have resulted to a more serious injury when facility staff allowed Resident 1 to bear weight to her right leg during sit to stand activity (the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed) without knowing Resident 1 had a right femoral fracture. (Reference F689) Findings: During a review of the Face sheet (A one-page summary of important information about a resident) indicated Resident 1 was admitted on [DATE] with diagnosis including but not limited to: Diabetes Mellitus (disease that result in too much sugar in the blood); Hypertension (High Blood Pressure); and Neurocognitive Disorder (decreased mental function due to a medical disease other than a psychiatric illness). 1. During a review of the document titled Post-Fall Review dated 10/21/23 indicated Resident 1 was found lying at the hallway on 10/21/23 at 7:00 p.m. The document indicated Rehab post-fall screen under the IDT Review Summary and Recommendations. During a review of the Progress Note for Resident 1 dated 11/10/23 at 1:20 p.m. indicated the Director of Nursing (DON) requested a fall screen on 11/10/23 related to an unwitnessed fall on 10/21/23. The Progress Note indicated skilled therapy (services that are reasonable and necessary to treat illness or injury, performed by or under supervision of a licensed therapist) was not indicated due to a pending right hip x-ray result and clearance from the doctor. (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 with the OT (Occupational Therapist - a healthcare provider who helps you improve your ability to perform daily tasks) on 2/08/24 at 10:19 a.m., when the OT was asked if Resident 1 received OT (Occupational Therapy - branch of health care that focuses on improving the patient's ability to perform activities of daily living) screening after the 10/21/23 fall incident, the OT stated the rehabilitation staff did not receive a referral from the nursing staff for Resident 1 until 11/10/23. She stated the DON asked the OT to screen Resident 1 due to Resident 1 ' s fall on 10/21/23; however, the OT stated skilled therapy was not started due to pending x-ray result. When the OT was asked how would the rehabilitation staff know if a resident needed rehabilitation screening, she stated the facility IDT (Interdisciplinary Team - group of health care professionals who work together toward the goals of the resident) would meet every morning to discuss clinical issues including but not limited to change of conditions and fall incidents. The OT stated the referral would come from the nursing staff if a resident needed rehabilitation screening. During an interview with the PT (Physical Therapist - a health specialist who evaluates and treats human body disorders) on 2/08/24 at 10:25 a.m., when the PT was asked if Resident 1 received PT (branch of health care that focuses on improving the patient's ability to move their body) screen after her fall on 10/21/23, he stated Resident 1 did not receive PT screen right after her fall incident; however, he stated Resident 1 received PT evaluation on 11/21/23 and was treated for over a week prior to Resident 1 ' s transfer to the hospital. When the PT was asked about their process for rehab screening, he stated after receiving a referral from the nursing staff, rehab screen will be completed right away. During an interview with the MDS (Minimum Data Set - an assessment tool completed by clinical staff to identify potential resident problems, strengths, and preferences) Coordinator (a nursing professional who helps manage a nursing team in a medical facility) on 2/08/24 at 11:48 a.m., the MDS Coordinator verified that he participated with the post fall review for Resident 1 on 10/21/23. The MDS Coordinator verified there was a recommendation for Resident 1 to have a rehab post-fall screen. When the MDS Coordinator was asked who made the referral to rehabilitation staff for Resident 1 ' s rehabilitation screening, he stated the Director of Rehabilitation (DOR) also participated with the post fall review and there was no need for nursing staff to make a referral; however, he stated the DOR no longer work for the facility and could not verify whether the DOR passed the information to the rehabilitation staff. Review of the Facility policy and procedure titled Therapy Screenings (no date) indicated therapists will conduct a brief, hands off resident assessment which consists of a review of the medical chart and resident observation when appropriate to determine if a therapy evaluation is warranted. Screenings will be conducted with consideration of federal, state, and facility requirements. The policy indicated, Residents identified as having a significant change by the facility will be screened by the therapy and recommended for skilled or restorative intervention. 2. During a review of the Progress Note dated 11/03/23 at 3:09 p.m. indicated Resident 1 complained of right hip pain and a request for a STAT (translates to immediately) X-ray was sent to Resident 1 ' s Primary Care Physician (PCP). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the Progress Note dated 11/09/23 at 12:16 a.m. indicated the x-ray provider was called to follow up about the request for STAT x-ray for Resident 1 ' s right hip; however, the Progress Note indicated the x-ray provider ' s representative was not able to find the request form. During a review of the document titled Order Summary Report for Resident 1, the document indicated a doctor ' s order written on 11/09/23 for a right hip STAT x-ray. During a review of the Progress Note dated 11/13/23 at 9:32 a.m., the Progress Note indicated the x-ray provider was called to follow about the right hip x-ray result for Resident 1. The Progress Note indicated the x-ray result was received via fax showing Resident 1 had a right femoral neck fracture and Resident 1 ' s PCP was notified. During a review of the document titled Documentation Survey Report for November 2023, the document indicated from 11/03/23 to 11/13/23, Resident 1 was allowed to do a sit to stand activity six times during morning shift and six times during evening shift. During a review of the Progress Note dated 11/21/23 at 11:51 a.m., the Progress Note indicated Licensed Staff B followed up with Resident 1 ' s PCP regarding an update for Resident 1 ' s right hip fracture. The Progress Note indicated Resident 1 ' s PCP gave an order for non-weight bearing (NWB -resident must not put any weight through the affected leg or foot) to Resident 1 ' s right leg. During a record review and concurrent interview with the DON on 2/08/24 at 1:18 p.m., the Progress Note dated 11/03/23 at 3:09 p.m. indicated Resident 1 had a recent fall and had complained of right hip pain. The Progress Note indicated a request for a STAT X-ray was sent to the doctor and the incoming nurse was made aware. The DON verified there was no follow-up progress note from the nurses related to the requested x-ray until 11/09/23. When the DON was asked about her expectations from the nurses when a resident had a change of condition, she stated nurses were expected to inform the doctor of any change of condition; document if there were any doctor ' s order and make sure to follow the order. The DON stated if a request was sent to the doctor and did not get an answer by the end of shift, the nurse was expected to communicate this to the incoming nurse for follow-up. The DON stated the nurses should have not waited until 11/09/23 to follow-up on the requested x-ray for Resident 1 and should have not waited 8 days to obtain an order for weight bearing precaution after learning that Resident1 had a right femoral fracture.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 44968 Based on interviews and records review, the facility failed to assess and provide necessary services to prevent the worsening of facility-acquired pressure ulcer (injuries to skin and underlying tissue resulting from prolonged pressure on the skin) for one of two sampled residents (Resident 1) when Resident 1 was found to have an open wound on her sacrum (the triangular bone just below the backbone) and coccyx (the tailbone) and the facility failed to: 1. Obtain a doctor ' s order for a routine wound treatment when a sacral wound was identified; 2. Assess and document the status of wound perimeter (refers to the surrounding area of the wound edge), wound bed (the base or open area of a wound) and healing progress as part of the pressure ulcer care plan; and 3. Conduct a comprehensive nutritional assessment for Resident 1 according to facility policy on Prevention of Pressure Injuries (localized damage to the skin as well as underlying soft tissue, usually occurring over a bony prominence or related to medical devices). These failures resulted to the worsening of Resident 1 ' s sacral wound as evidenced by the development of thick adherent (a close and persistent attachment) devitalized (also called slough [a yellow, tan, green or brown in color and may be moist, loose, and stringy) necrotic (dead) tissue and an increased in wound size from 0.5 cm. (centimeter- a metric unit of length) x (by) 0.7 cm to 3.3 cm in length, 1.5 cm in width and 0.1 cm in depth. Findings: During a review of the Minimum Data Set (MDS - an assessment tool completed by clinical staff to identify potential resident problems, strengths, and preferences) dated 9/29/23, indicated Resident 1 had a short and long term memory problem. Her cognitive (relating to the mental process involved in knowing, learning, and understanding things) skills for daily decision making was severely impaired. The MDS indicated Resident 1 required extensive (resident involved in activity; staff provide weightbearing support [staff supports some of the weight of the resident])) one person physical assistance with bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture). During a review of the Pressure Ulcer Care Plan initiated on 11/22/23 indicated care plan interventions to include but not limited to: Administer treatments as ordered and monitor for effectiveness; Assess/record/monitor wound healing. Measure length, width, and depth where possible. Assess and document status of wound perimeter, wound bed, and healing progress. Report improvements and declines to the MD (Medical Doctor); Encourage to reposition self as tolerated; and Nutritional supplement as ordered for wound healing. 1. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a review of the Progress Note dated 11/22/23 at 7:49 p.m. and concurrent interview with Licensed Staff B on 2/08/24 at 11:14 a.m., the progress note indicated Resident 1 was noted with 4.5 cm x 4.5 cm of non-blanchable redness (skin redness that do not fade when a person presses on them) to sacrococcyx area (pertaining to both the sacrum and coccyx) with an open wound measuring 0.5 cm x 0.7 cm., and was treated with Medihoney (a brand name wound and burn gel). When Licensed Staff B was asked if Resident 1 ' s physician gave the order to treat the wound with medihoney, Licensed Staff B stated yes; however, after review of the Physician ' s Order for November 2023 with Licensed Staff B, she stated there was no order written for medihoney on 11/22/23. She stated she got the order herself from the physician and could have forgotten to enter a physician ' s order. Licensed Staff B stated there was a doctor ' s order written on 11/24/23 to cleanse the sacral wound and apply Medi honey every day. During a review of the Treatment Administration Record (TAR) for November 2023 and concurrent interview with Licensed Staff B on 2/08/24 at 11:21 a.m., the TAR indicated an order written on 11/24/24 to cleanse the sacral wound and apply Medihoney every day. Licensed Staff B verified that the initial wound treatment was done on 11/25/23. When Licensed Staff B was asked if she would know if wound treatment was provided to Resident 1 on 11/23/23 and 11/24/23, she stated no. She stated there was no other wound treatment order written on the TAR except for the 11/24/23. During a review and concurrent interview with the Director of Nursing (DON) on 2/08/24 at 1:35 p.m., the Progress Note dated 11/22/23 at 10:00 p.m. indicated Resident 1 ' s sacral wound was treated with Medihoney, however; after review of the Physician ' s order with the DON, the DON verified there was no written treatment order for Resident 1 ' s sacral wound on 11/22/23. When the DON was asked about her expectations form nurses when providing wound treatment to the residents, she stated, nurses cannot dispense any medication without a doctor ' s order. She stated she expected the nurses to obtain a doctor ' s order for any medication prior to medication or treatment administration following the five rights (right patient, right drug, right time, right dose, right route) of medication administration. 2. During a review of the Progress Note dated 11/23/23 at 2:42 p.m., the Progress Note indicated Resident 1 was monitored for pressure ulcer to her sacrococcyx. The Progress Note indicated, No active bleeding and no signs and symptoms of infection noted. During a review of the Progress Note dated 11/24/23 at 3:31 p.m., the Progress Note indicated, Resident 1 was monitored for pressure ulcer. The Progress Note indicated, No signs and symptoms of infection. During a review of the Progress Note dated 11/25/23 at 4:31 p.m., the Progress Note indicated Resident 1 was monitored for pressure ulcer to coccyx. The Progress Note indicated, No active bleeding and no symptoms of infection. During a review of the Progress Note dated 11/26/23 at 3:11 p.m., the Progress Note indicated Resident 1 was monitored for pressure ulcer to sacrococcyx and was repositioned every 2 hours as needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555214	A. Building B. Wing	02/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Professional Post Acute Center	81 Professional Center Parkway San Rafael, CA 94903

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a review of the document titled Initial Wound Evaluation & Management Summary dated 11/28/23 indicated Resident 1 had an Unstageable DTI (Deep Tissue Injury - a form of pressure ulcer or pressure sore. A full thickness skin loss in which the base of the ulcer is covered by slough and /or eschar [a necrotic tissue characterized as dry, thick, leathery tissue that is often tan, brown or black]) to her sacrum with the wound measuring 3.3 cm in length, 1.5 cm in width and 0.1 cm in depth. The document indicated the wound had 60% (percent) of thick adherent devitalized necrotic tissue and 40% granulation tissue (reddish connective tissue [made up of cells, fibers, and a gel-like substance that forms on the surface of a wound when the wound is healing]). During a review of the Treatment Administration Record (TAR) for November 2023 and concurrent interview with the Treatment Nurse on 2/08/24 at 12:20 p.m., the TAR for Resident 1 indicated the Treatment Nurse ' s initial on 11/27/28. The Treatment Nurse verified she provided the wound treatment to Resident 1 ' s sacral pressure ulcer on 11/27/23; however, when the Treatment Nurse was asked if she noted any changes to Resident 1 ' s sacral wound during treatment, she stated no. She stated she would document in Resident1 ' s record if she observed any change. During an interview and concurrent record review with the Treatment Nurse on 2/08/24 at 12:37 p.m., the Treatment nurse stated she had a Progress Note dated 11/28/23 at 2:41 p.m. that Resident 1 was noted with unstageable DTI to her sacrum; however, the Treatment Nurse concurred that her note was based from the wound doctor ' s assessment. When the Treatment Nurse was asked if there were any notes from the nurses indicating Resident 1 ' s sacral wound had worsened prior to the wound doctor ' s visit and that the doctor was notified, she stated no. During an interview with the DON on 2/08/24 at 1:35 p.m., when the DON was asked about her expectations on what the nurses would document when assessing a pressure ulcer, the DON stated she expected for the nurses to document how the wound bed looked like, any necrotic tissue, slough observed, if it is improving or worsening, any signs of infection, if the wound treatment was effective. The DON stated she expected the nurses to notify the physician for any changes and obtain new treatment order if appropriate. During an interview with Licensed Staff D on 2/15/24 at 11:05 a.m., when Licensed Staff D was asked about the facility ' s practice for skin assessment, Licensed Staff D stated licensed nurses were to conduct a skin assessment on admission then weekly. He stated nurses were to document on the weekly nursing progress note for any new and active skin issues to keep track of any skin improvement or worsening. He stated the Progress Note should describe the condition of the wound including wound measurement, drainage, or bleeding if any, presence of odor, and signs of infection. After review of the Weekly Nursing Progress Note dated 11/26/23 for Resident 1 with Licensed Staff D, Licensed Staff D verified the Progress Note indicated, No new skin issue noted. Licensed Staff D verified the Progress Note did not indicate that Resident 1 had an open wound to her sacrum. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview and concurrent record review with Unlicensed Staff E on 2/15/24 at 11:10 a.m., when Unlicensed Staff E was asked how often did the direct care staff check the residents for any skin changes, Unlicensed Staff E stated resident ' s skin was constantly checked when providing incontinence (involuntary or accidental leakage of urine [wee] or feces [poo]) care (assisting a resident to apply or change incontinence products like absorbent pads) and every time shower or bed bath was provided. She stated CNAs (Certified Nursing Assistant) would report to the nurse using the facility ' s Stop and Watch tool (an early warning communication tool that CNAs can use to alert a nurse if they notice something different in a resident ' s daily care routine) if a new or worsening skin issue was observed. After review of the document titled Documentation Survey Report for Resident 1 from 11/23/23 to 11/28/23 with the Unlicensed Staff E, Unlicensed Staff E verified that on 11/25/23, A Stop and Watch alert was created indicating a new skin observation and was reported to the nurse. 3. During an interview and concurrent record review with the Registered Dietician (RD) on 2/08/24 at 1:04 p.m., when the RD was asked about her process when a resident was found to have pressure ulcer, the RD stated she would do a full nutritional assessment and will provide recommendations as needed to assist with wound healing. When the RD was asked if Resident 1 was assessed after she was noted to have sacral pressure ulcer, she stated she was on training with the facility RD prior to Resident 1 ' s hospital transfer. She stated the outgoing RD gave her a list of residents who were being monitored for pressure ulcer which did not include Resident 1. The RD also verified there was no comprehensive nutritional assessment for November 2023 from the previous RD for Resident 1 after the identification of the sacral pressure ulcer on 11/22/23. Review of the Facility policy and procedure titled Prevention of Pressure Injuries revised on April 2020 indicated under Nutrition of the Prevention list to, Conduct a comprehensive nutritional assessment for any resident at risk of pressure injury who is screened to be at risk for malnutrition; and for all adult residents with a pressure injury. Review of the Facility policy and procedure titled Nutritional Assessment revised on December 2011 indicated, The Dietician, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission (within current initial assessment timeframes) and as indicated by a change of condition that places the resident at risk for impaired nutrition.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44968 Based on observation, interviews, and records review, the facility failed to provide staff supervision for transfer and ambulation to one of two sampled residents (Resident 1) when Resident 1 required extensive (resident involved in activity; staff provide weightbearing support [staff supports some of the weight of the resident]) one-person physical assist with transfers and ambulation and was found lying at the hallway. This failure resulted in Resident 1 sustaining a right femoral fracture (a break in the thigh bone) and subsequently had a significant physical functional (the ability to perform basic and instrumental activities of daily living) decline. Findings: During a review of the Face sheet (A one-page summary of important information about a resident) indicated Resident 1 was admitted on [DATE] with diagnosis including but not limited to: Diabetes Mellitus (disease that result in too much sugar in the blood); Hypertension (High Blood Pressure); and Neurocognitive Disorder (decreased mental function due to a medical disease other than a psychiatric [relating to mental] illness). During a review of the Minimum Data Set (MDS - an assessment tool completed by clinical staff to identify potential resident problems, strengths, and preferences) dated 9/29/23 indicated Resident 1 had a short and long term memory problem. Her cognitive (relating to the mental process involved in knowing, learning, and understanding things) skills for daily decision making was severely impaired. The MDS indicated Resident 1 required extensive one person physical assistance with transfers to and from a bed to a chair (or wheelchair); and ambulation. During a review of the document titled Post-Fall Review dated 10/21/23 indicated Resident 1 was found lying at the hallway on 10/21/23 at 7:00 p.m. The document indicated Resident 1 was last observed lying in bed/sleeping prior to the fall. During an observation of Resident 1 ' s room location on 12/26/24 at 11:02 a.m., Resident 1 ' s room was located at the middle of the hallway away from the nurses ' station. During a review of the Progress Note dated 11/03/23 at 3:09 p.m. indicated Resident 1 complained of right hip pain and a request for a STAT (translates to immediately) X-ray (a type of medical imaging that creates pictures of the bones and soft tissues) was sent to Resident 1 ' s Primary Care Physician (PCP). During a review of the document titled Radiology Interpretation dated 11/11/23 indicated Resident 1 had a right femoral fracture. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of the document titled Physical Therapy (PT) Evaluation and Plan of Treatment dated 11/21/23 and concurrent interview with Physical Therapist (PT) on 2/08/24 at 10:31 a.m., the document indicated Resident 1 exhibited a significant functional decline due to a right hip fracture as a result from a fall. The PT stated Resident 1 required maximum assistance with transfers and did not ambulate (walk) during her therapy sessions due to Resident 1 was put on non-weight bearing (NWB -resident must not put any weight through the affected leg or foot) to her right leg and was not able to follow weight bearing precautions due to Dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). During an interview with Unlicensed Staff A on 12/26/23 at 1:11 p.m., when Unlicensed Staff A was asked how much staff assistance Resident 1 needed to walk and transfer from bed to wheelchair and back to her bed prior to her fall on 10/21/23, Unlicensed Staff A stated Resident 1 required extensive assist with both transfers and ambulation. Unlicensed Staff A stated Resident 1 subsequently became dependent from staff with transfer following her fall and did not ambulate. Unlicensed Staff A also stated Resident 1 spent most of the time in bed after falling. During an interview with Licensed Staff B on 2/08/24 at 11:14 a.m. when Licensed Staff B was asked if Resident 1 could transfer and walk without staff assistance, Licensed Staff B stated no; however, when asked how Resident 1 managed to transfer and walk from her room to the hallway and subsequently was found lying on the hallway on 10/21/23, she stated she did not know what happened. During an interview and concurrent record review with the MDS Coordinator (a nursing professional who helps manage a nursing team in a medical facility) on 2/08/24 at 11:48 a.m., the MDS Coordinator stated Resident 1 required extensive one person physical assistance with transfers and ambulation prior to her fall on 10/21/23. After review of the MDS dated [DATE] with the MDS Coordinator, the MDS Coordinator stated Resident 1 had a decline with her ability to transfer from extensive one person assist to being dependent with staff. The MDS Coordinator also stated Resident 1 did not walk during the seven day observation period (11/19/23 to 11/25/23). Review of the Facility policy and procedure titled Activities of Daily Living (ADL), Supporting revised on March 2018 indicated, Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with mobility (transfer and ambulation, including walking)