STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555226	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs Healthcare Center at the Carlotta	41505 Carlotta Drive Palm Desert, CA 92211

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46145 Based on interview and record review, the facility failed to provide treatment and services consistent with the professional standards of practice, to prevent progression of pressure injuries (PI-damage to the skin and underlying tissue due to prolonged pressure) for two of three sampled residents (Residents 1 and 2) when: 1. For Resident 2, a consistent weekly skin assessment was not completed to evaluate the changes in the resident's redness to the coccyx identified on admission. In addition, the facility failed to initiate treatment for Resident 2's redness to the coccyx upon admission. These failures resulted in Resident 2's coccyx (tailbone) redness to worsen into a Stage 3 pressure injury (full thickness tissue loss). 2. For Resident 1, a consistent weekly skin assessment was not completed to evaluate the changes in the resident 's Stage 2 PI (shallow opening with loss of middle layer of skin) of the coccyx and left buttocks, and reddened sacrum (is a triangle-shaped bone between your hip bones) identified on admission. This failure had the potential for Resident 1 ' s coccyx PI to progress without the knowledge of staff, subsequently delaying provision of treatment. Findings: 1. On May 20, 2024, at 9 a.m., an unannounced visit to the facility was conducted to investigate a quality care issue. A review of Resident 2 ' s medical record titled, Admission Record, indicated the resident was admitted to the facility on [DATE], with diagnoses which included fractured (break in continuity of bone) left patella (Kneecap), and was discharged from the facility on May 20, 2024, for a left hip replacement surgery. A review of Resident 2 ' s admission skin assessment dated , April 26, 2024, indicated the resident had redness to the coccyx on admission to the facility. (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 0686 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 2 ' s Minimum Data Set (MDS-a standardized assessment tool that measures health status in nursing home residents), Section M- Skin Condition, dated May 2, 2024, did not reflect any skin impairment for Resident 2. The MDS assessment did not reflect the redness in the coccyx area of Resident 2 which was observed during admission to the facility on [DATE]. A review of Resident 2 ' s admitting physician orders for April 2024, did not indicate any treatment for redness on Resident 2's coccyx. A review of Resident 2 ' s Treatment Administration Record (TAR) for April 2024, indicated resident was not receiving wound care treatments for redness on Resident 2's coccyx area. On May 20, 2024, at 1:40 p.m., a concurrent interview and record review of Resident 2's medical record was conducted with the Director of Nursing (DON). The DON stated the following: a. The resident was identified with a deep tissue injury (DTI- persistent non-blanchable deep red, purple, or [NAME] areas of intact skin, non-intact skin, or blood-filled blisters) measuring 3 X (by) 1 cm (centimeter- unit of measurement) on the resident's bottom. b. Treatment (Tx) Nurse 2 received a physician order for the treatment of the DTI and did not transcribe the orders to the resident ' s medical record. c. The expectations were for nursing staff to report the skin assessment findings to the physician, obtain treatment orders, and transcribe the orders Right away, so treatments can be carried out as soon possible. On May 20, 2024, at 3:00 p.m., an interview was conducted with Tx Nurse 1. TX Nurse 1 stated a referral would be made for a resident to be evaluated by the Wound Care Specialist (WCS) Nurse Practitioner, if a resident was found to have skin impairments. In addition, she (TX nurse) was expected to complete skin assessments weekly on each resident with pressure injury. On May 21, 2024, at 1:22 p.m. a concurrent interview and record review was conducted with Tx Nurse 1. The Tx Nurse 1 verified there was no weekly skin assessment completed for Resident 2. On May 21, 2024, at 1:40 p.m., a concurrent interview and record review was conducted with the DON, and she stated and verfied the following: a. During admission, the admissions nurse would complete skin assessment, followed by another skin assessment to be completed by the Tx Nurse, which would include measurement and staging of the pressure injury. b. The Tx Nurse would notify the physician if there were skin impairments and would be responsible in transcribing the treatment orders and initiating the treatments to the residents. c. The Tx Nurse did not conduct skin assessment on admission and there was no treatment provided to Resident 2 ' s reddened coccyx. d. Her expectations were for nursing staff to report the skin assessment findings to the physician, obtain treatment orders, document, and carry out the physician orders. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 2 ' s weekly assessment did not indicate a skin assessment was completed for Resident 2's pressure injury on the coccyx area, after admission on April 26, 2024. A review of Resident 2 ' s medical record titled, Changes of Condition (COC) progress note, dated, May 9, 2024, at 1:35 p.m., indicated, . (Resident 2) has a wound on her bottom, (Registered Nurse- RN) measured 3 X 1 cm. DTI to the coccyx area . The COC progress notes further stated, .(Dr) responded with the following . (order) . cleanse with normal saline, pat dry, apply collagen (skin protectant) to wound and cover with dry dressing . A review of Resident 2 ' s physician orders for the month of May 2024, indicated no treatment orders for Resident 2's DTI on the coccyx. There was no documentation reflecting the treatment order for the DTI, indicated in the progress notes dated May 9, 2024. A review of Resident 2 ' s TAR for May 2024, did not reflect treatment initiated for the resident's DTI to the coccyx found on May 9, 2024. A review of Resident 2 ' s Wound Care Specialist (WCS) skin assessment, dated May 16, 2024, indicated, . (Left) Ischium (Stage) 3 (measuring) 0.6 X 0.8 X 0.2 cm w/ (with) odor, signs & symptoms (S/S) of infection, c/o pain . Tx order recommendations: cleanse with normal saline, honey (skin protectant), cover with Alginate, daily. A review of Resident 2 ' s physician orders, dated May 16, 2024, indicated .Cleanse left ischium with Normal saline, pat dry, apply honey and alginate, cover with dry dressing. Every day shift . A review of Resident 2 ' s TAR, for May 2024, indicated, the resident began receiving treatment for the Stage 3 on the left ischium on May 17, 2024, until discharge on [DATE]. On June 5, 2024, at 9:20 a.m., a concurrent interview and record review of Resident 2's medical records was conducted. The DON reviewed the admission skin assessment, the change of condition progress notes dated May 9, 2024, and the WCS skin assessment dated [DATE]. The DON verified the resident ' s ischium wound noted by WCS which was observed to be a Stage 3 would be referring to the coccyx identified as reddened on admission (April 26, 2024) and on May 9, 2024. On June 5, 2024, at 12:12 p.m., during an interview, Tx Nurse 2 stated if there was a change of condition related to skin, the Tx nurse would assess the skin impairment, notify the physician of the findings, obtain treatment (TX)orders (if any), then transcribe the Tx orders into the resident ' s medical record. Tx nurse 2 verified she assessed and identified a DTI on Resident 2 ' s bottom and completed a change of condition progress notes on May 9, 2024, and she received treatment orders from the physician. Tx nurse 2 stated she did not transcribe the Tx orders into Resident 2 ' s medical records which delayed the provision of treatment to the resident ' s DTI on the coccyx. On June 5, 2024, at 3:50 p.m., a concurrent interview and record review was conducted with the MDS nurse. The MDS nurse verified she did not identify Resident 2's skin impairments during the admission assessment. The MDS nurse stated redness was not considered a wound. The MDS nurse further stated she did not verify with the admission nurse if the resident has a blanchable (redness that disappears on with applied pressure - indicating healthy skin) coccyx redness or non-blanchable (redness that does not disappear with applied pressure - indication stage 1 PI), stating, I should have. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of the facility Policy & Procedure (P & P), titled, Wound Care, revised, October 2010, indicated, . Wound Care . Purpose: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing . Preparation: 1. Verify that there is a physician ' s order for this procedure 2. Review the resident ' s care plan to assess for any special needs of the resident . Documentation: The following information should be recorded in the resident ' s medical records: 6. All assessment data (i.e., wound bed, color, size, drainage, etc.) obtained when inspecting the wound . Reporting: 2. Report other information in accordance with facility policy and professional standards of practice . A review of facility P & P, titled, Resident Examination and Assessment, revised, February 2014, indicated, . Purpose . is to examine and assess the resident for any abnormalities in health status, which provides a basis for the care plan . review the resident ' s admission assessment and/or preliminary care plan to assess for any special situations regarding the resident ' s care . 8. Skin: . e. presence of pressure sores, redness . Documentation: . 3. All assessment data obtained during the procedure . Reporting: . Notify the physician of any abnormalities such as, but not limited to: . e. Wounds or rashes on the resident ' s skin . 3. Report information in accordance with facility policy and professional standards of practice . A review of the facility P & P, titled, Comprehensive Assessments and the Care Delivery Process, revised December 2016, indicated, .Comprehensive assessments will be conducted to assist in developing person-centered care plans . Comprehensive assessments, care planning and the care delivery process involve collecting and analyzing information, choosing and initiating interventions, and then monitoring results and adjusting interventions . Monitoring results and adjusting interventions includes: a. Periodically reviewing progress and adjusting treatments . Comprehensive assessments are conducted and coordinated by a registered nurse with appropriate participation of other health professionals . Completed assessments . are maintained in the resident ' s active record These assessments are used to develop, review, and revise the resident ' s comprehensive care plan . A review of the facility P & P, titled, Medication and Treatment Orders, revised, July 2016, indicated, . 7. Verbal orders must be recorded immediately in the resident ' s chart by the person receiving the order and must include . the date and time of the order . 9. Orders . must include b. Number of doses, start, and stop date, and/or specific duration of therapy . B. A review of Resident 1 ' s medical records titled, Admission Record, indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included muscle weakness and spinal stenosis (spaces within the backbone becomes too small, causing pressure on the nerves and spinal cord). Further review of the admission record indicated Resident 1 discharged from the facility on April 15, 2024. A review of Resident 1 ' s admission skin assessment dated [DATE], indicated Resident 1 was identified with a Stage 2 PI on the coccyx and left buttocks; and sacral redness. A review of Resident 1 ' s Minimum Data Set (MDS-a standardized assessment tool that measures health status in nursing home residents) skin assessment, Section M, dated, April 10, 2024, indicated, the resident was identified with two Stage 2 PI ' s (coccyx & left buttocks) upon admission. A review of Resident 1 ' s admitting physician orders indicated the following: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	1. April 5, 2024, at 4:18 p.m., . Sacrococcygeal (lower back): Cleanse w/ (with) NS (normal saline) . apply barrier cream (skin protectant) . over blanchable redness . every day shift . 2. April 5, 2024, at 4:34 p.m., . Left (buttocks) open area: Cleanse . apply barrier cream . collagen (fibrous cover for wound) . foam dressing . everyday shift . 3. April 5, 2024, at 4:36 p.m., .Sacrum/coccyx (lower back) open areas: Cleanse . apply barrier cream, collagen . cover with foam . everyday shift . A review of Resident 1 ' s care plan titled, Resident has actual impairment to skin integrity of the coccyx (stage) 2, upon admission, initiated, April 9, 2024, indicated the following intervention, . Weekly treatment documentation to include measurement of each area of skin breakdown ' s width, length depth, type of tissue and exudate (drainage) and any other notable changes or observations . On May 20, 2024, at 3:00 p.m., during interview, Treatment (Tx) Nurse 1 stated treatment nurses would complete weekly skin assessments on each resident receiving PI wound treatments. Tx nurse 1 further stated skin assessment should be documented to reflect the most current status of the resident ' s pressure injury. Tx nurse 1 stated when a resident was identified with a skin impairment, a resident would be referred to a Wound Care Specialist (WCS), Nurse Practitioner. A review of Resident 1 ' s skin assessments notes, did not indicate documentation of WCS skin assessments. A review of Resident 1 ' s weekly progress notes did not indicate weekly skin assessments were completed to establish the status of Resident 1's pressure injuries on the left buttock and Sacro coccyx. On May 21, 2024, at 1:22 p.m. a concurrent interview and record review of Resident 1 ' s weekly PI skin assessments was conducted. TX nurse 1 verified no skin assessments were documented for Resident 1's pressure injury on the coccyx, sacrum, and left buttocks. TX nurse 1 stated there was no documented weekly skin assessments for Resident 1's pressure injury (coccyx, left buttock, and sacral area). On May 21, 2024, at 2:00 p.m., during an interview, the Director of Nursing (DON) stated the nurses should complete weekly skin assessments on all resident with PI ' s. The DON verified Resident 1 did not have weekly skin assessments addressing pressure injuries. The DON stated skin assessments are important to evaluate the condition of the resident ' s PI. The DON stated she did not know why Resident 1 was not assessed by the WCS. The DON stated the resident was at the facility for 10 days, and he should have been seen by the WCS. A review of the facility Policy & Procedure (P & P), titled, Wound Care, revised, October 2010, indicated, . Wound Care . Purpose: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing . Preparation: 1. Verify that there is a physician ' s order for this procedure 2. Review the resident ' s care plan to assess for any special needs of the resident . Documentation: The following information should be recorded in the resident ' s medical records: 6. All assessment data (i.e., wound bed, color, size, drainage, etc.) obtained when inspecting the wound . Reporting: 2. Report other information in accordance with facility policy and professional standards of practice . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of facility P & P, titled, Resident Examination and Assessment, revised, February 2014, indicated, . Purpose . is to examine and assess the resident for any abnormalities in health status, which provides a basis for the care plan . review the resident ' s admission assessment and/or preliminary care plan to assess for any special situations regarding the resident ' s care . 8. Skin: . e. presence of pressure sores, redness . Documentation: . 3. All assessment data obtained during the procedure . Reporting: . Notify the physician of any abnormalities such as, but not limited to: . e. Wounds or rashes on the resident ' s skin . 3. Report information in accordance with facility policy and professional standards of practice . A review of the facility P & P, titled, Comprehensive Assessments and the Care Delivery Process, revised December 2016, indicated, .Comprehensive assessments will be conducted to assist in developing person-centered care plans . Comprehensive assessments, care planning and the care delivery process involve collecting and analyzing information, choosing and initiating interventions, and then monitoring results and adjusting interventions . Monitoring results and adjusting interventions includes: a. Periodically reviewing progress and adjusting treatments . Comprehensive assessments are conducted and coordinated by a registered nurse with appropriate participation of other health professionals . Completed assessments . are maintained in the resident ' s active record These assessments are used to develop, review, and revise the resident ' s comprehensive care plan .