

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555326	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/26/2024
NAME OF PROVIDER OR SUPPLIER Carmel Mountain Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 11895 Avenue of Industry San Diego, CA 92128	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220</p> <p>Based on observation, interview, and record review, the facility failed to follow the physicians' plan of care related to skin and wound treatments for three of three residents (Residents 1, 2, and 3) reviewed for Comprehensive Care Plans.</p> <p>This failure had the potential for Resident 1, 2, and 3's skin and wound injuries to worsen.</p> <p>Findings:</p> <p>1. Resident 1 was readmitted to the facility on [DATE], with diagnosis which included Amyotrophic Lateral Sclerosis (ALS-a progressive nervous system disease that affects the brain and spinal cord), resulting in functional quadriplegia (unable to move all four limbs), per the facility's Admission Record.</p> <p>Resident 1's clinical record was reviewed on 12/17/24:</p> <p>According to the facility's Admission Note, dated 10/25/24, Resident 1 was readmitted from the hospital with documented skin injuries to the right and left scapula (shoulder blades), and right buttocks, all described as deep tissue injuries (a type of pressure ulcer where the underlying soft tissues, like muscles and fat, are damaged by sustained pressure or shear forces); Additionally noted were reddened areas to the right and left sides of the head, left shoulder, sacralcoccyx (bottom of spine), along with the right and left heels.</p> <p>According to the physician orders, dated 10/25/24, cleanse left and right mid-occipital sides of head with normal saline, apply Medi honey (a wound care product), apply gauze, every day. Cleanse right and left scapula with normal saline, apply betadine and gauze dressing every day. Cleanse left shoulder with normal saline, apply skin prep (topical antiseptic) solution apply gauze, every day. Right buttocks cleanse with normal saline, apply triad paste (a medication that facilitate healing), apply gauze, every day. Sacralcoccyx cleanse with normal saline, apply tirade paste, apply gauze, every day. Right foot lateral (outer side) abrasion/lesion cleanse with normal saline, apply xeroform dressing and cover with gauze, every day. Right and left heel, cleanse with normal saline, apply prep solution followed by dry dressing, every day.</p> <p>According to the Wound Care Specialist notes, weekly evaluations were initiated on 10/29/24 and continued weekly, until 11/26/24.</p> <p>(continued on next page)</p>

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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Treatment Administration Record (TAR) was viewed from 10/25/24 through 10/31/24. No skin/wound treatments were documented as being performed by Licensed Nurses on 10/27/24 (Sunday).</p> <p>The TAR for 11/1/24 through 11/30/24 was reviewed. No skin/wounds treatments were documented as being performed by Licensed Nurses on 11/2/24 (Saturday) and 11/9/24 (Saturday).</p> <p>According to the care plan, titled Skin Care, dated 10/25/24, interventions listed included Administer treatments as ordered and monitor for effectiveness. Assess/document/monitor wound healing .</p> <p>According to the facility's Transfer Form, Resident 1 was transported to the hospital on 11/30/24 due to a decreased level of consciousness. The resident had not returned to the facility, per the facility's census, dated 12/17/24.</p> <p>An interview and record review was conducted with Treatment nurse 3 (Tx LN 3) on 12/19/24 at 12:10 P.M. Tx LN 3 stated Resident 1 was readmitted with many skin injuries, after her last hospitalization . Tx LN 3 stated she performed all the wound treatments in the sub-acute unit (a specialized unit that provides a higher level of care) and she worked Monday through Friday. Tx LN 3 reviewed Resident 1's TAR and stated two wound treatments were not documented in November. Tx LN 3 checked the dates and stated both dates (11/2/24 and 11/9/23) were on the weekend, and charge nurses were expected to perform weekend wound treatments. Tx LN 3 stated by not performing all the wound treatments as ordered by the physician, Resident 1 was at risk of the wounds becoming infected.</p> <p>2. Resident 2 was admitted to the facility on [DATE], with diagnoses which included pressure ulcer of sacral (bottom of the spine) region, Stage 4 (the worst stage, involving full thickness tissue loss with exposed bone, tendon, or muscle), and pressure ulcer of right buttocks, unstageable (unable to see the depth of the wound, preventing accurate staging), per the facility's Admission Record.</p> <p>An observation of Resident 2's wound dressing change was conducted on 12/19/24 at 11:49 A.M. with Treatment nurse 1 (Tx LN 1) and TX LN 2, after permission was granted by Resident 2. The dressing change was conducted with a clean and correct technique.</p> <p>Resident 2's clinical record was reviewed on 12/17/24:</p> <p>According to the physician's order, dated 10/24/24, Sacral area, cleanse with normal saline, apply wet to dry dressing (moist gauze with vashe {a sterile wound cleaner} solution) then cover with foam dressing due to pressure ulcer, every day.</p> <p>The Treatment Administration Record (TAR) was reviewed from 12/1/24 through 12/17/24. There was no documented evidence wound treatments were performed by Licensed Nurses on 12/11/24 (Wednesday) and 12/12/24 (Thursday).</p> <p>According to the care plan, titled Pressure Ulcers, dated 10/24/24, listed interventions such as .Administer treatments as ordered . Assess/document/monitor wound healing .</p> <p>3. Resident 3 was admitted to the facility on [DATE], with diagnoses which included pressure ulcer of sacral region Stage 4, per the facility's Admission Record.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation of Resident 3's wound dressing change was conducted on 12/19/24 at 11:17 A.M. with Tx LN 1 and TX LN 2, after permission was granted by Resident 3. The dressing change was conducted with a clean and correct technique.</p> <p>Resident 3's clinical record was reviewed on 12/17/24:</p> <p>According to the physician's order, dated 11/20/24, cleanse sacral-coccyx (bottom of spine) with normal saline, apply collagen powder (a wound care product) followed by vashe soaked gauze, wet to dry, then cover with foam dressing, every day.</p> <p>The TAR was reviewed 11/20/24 through 11/30/24. There was no documented evidence a wound treatment was performed by Licensed Nurses on 11/29/24 (Friday).</p> <p>The TAR was reviewed from 12/1/24 through 12/17/24. There was no documented evidence a wound treatment was performed by Licensed Nurses on 12/15/24 (Sunday).</p> <p>According to the care plan, titled Pressure Ulcers noted on admission, dated 9/10/24, interventions listed such as .Administer treatments as ordered . Assess/document/monitor wound healing .</p> <p>An interview was conducted with Tx LN 1 on 12/19/24 at 11:59 A.M. Tx LN 1 stated all wound treatments needed to be documented, so other staff were informed the treatments were completed. Tx LN 1 stated if a treatment was not documented, it was considered not done. Tx LN 1 stated if treatments were missed, the residents were at risk of infection or a worsening wound.</p> <p>An interview was conducted with the Director of Nursing (DON) on 12/19/24 at 12:31 P.M. The DON stated she expected all nurses to perform wound care as directed by the physician, and to document the care was provided. The DON stated if the treatment was not documented, it was not done. The DON stated by licensed nurses not completing wound care, residents were at risk of infection.</p> <p>According to the facility's policy, titled Physician's Orders, undated, .It is the policy of this facility to accurately transcribe and implement orders .in accordance to the resident's plan of care .6. Medication, treatment or related orders are transcribed in the eMAR, eTAR accurately and verified .</p> <p>According to the facility's policy, titled Skin Management System, dated March 2013, .6. A report of all wound progress will be updated by the licensed staff .10. The Medical Records designee shall conduct treatment record reviews to ensure administration of treatments .</p>		