STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555328	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fountain Valley Post Acute	11680 Warner Avenue Fountain Valley, CA 92708

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 - Minimal harm or potential for 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** 46128 Based on observation, interview, medical record review and facility P&P review, the facility failed to provide the necessary care and services to prevent the development or worsening of pressure injuries for two of two sampled residents (Residents 1 and 2). * The facility failed to assess Resident 1's skin when readmitted to the facility and failed to develop a care plan to address Resident 1's coccyx wound. * The facility failed to revise Resident 2's care plan to address Resident 2's Stage 3 pressure injury and failed to ensure Resident 2 received his wound treatment with his own wound medication supply. These failures had the potential for Residents 1 and 2 not to receive the appropriate care and services to promote healing of the pressure injury. Findings: 1. Review of the facility's P&P titled Admission Notes (undated) showed should a resident be discharged from and readmitted to the facility, the new admission data must be recorded. Review of the facility's P&P titled Guidelines for Charting and Documentation revised 4/2012, under the section for Nursing Summaries and/or Assessment for skin-hair-scalp-nails, showed dry moist, scaly, etc., be descriptive of lesion, edema; etc., include location, size, depth, color, amount, consistency, odor of drainage, and status of tissue and surrounding area, and indicate the type of treatment and how often the treatment is administered. Medical record review for Resident 1 was initiated on 10/3/24. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. a. Review of Resident 1's Admission/Readmission Evaluation/assessment dated [DATE], showed the question asking if the resident had wounds or skin integrity concern present upon admission, the documented answer was no. However, the Comment section showed per report coccyx wound. Review of Resident 1's Order Summary Reported showed a physician's order dated 9/29/24, to cleanse the coccyx wound with normal saline, pat dry, apply triad cream (skin treatment), and cover with a dry dressing once daily. (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 - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 1's medical record failed to show documented evidence Resident 1's skin was assessed to include the descriptions and/or status of tissue of the reported coccyx wound upon readmission on 9/29/24. On 10/3/24 at 1505 hours, an interview and concurrent medical record review was conducted with RN 1. When asked about the skin assessments, RN 1 stated the skin assessments were performed during the resident's admission and readmission to check for any pressure ulcers or any skin changes. RN 1 verified there was no comprehensive skin assessment done when Resident 1 was readmitted to the facility on [DATE]. b. Review of Resident 1's Plan of Care revised on 8/16/24, showed a care plan problem addressing Resident 1's risk for skin breakdown related to Braden Risk score of 11 (high risk). Review of Resident 1's Plan of Care revised on 8/28/24, showed a care plan problem addressing Resident 1's risk for skin breakdown related to generalized weakness, lethargy (fatigue), bladder incontinence, history of CVA, right sided weakness, and PVD. Review of Resident 1's Order Summary Report showed a physician's order dated 9/29/24, to cleanse the coccyx wound with normal saline, pat dry, apply triad cream (skin treatment), and cover with a dry dressing once daily. Further review of Resident 1's Plan of Care failed to show a care plan problem was developed to address Resident 1's coccyx wound. On 10/4/24 at 1517 hours, an interview and concurrent medical record review was conducted with LVN 1. When asked why the care plan was necessary, LVN 1 stated to know the plans and goals for the resident's wound. LVN 1 verified there was no care plan developed to address Resident 1's coccyx wound. 2. Medical record review for Resident 2 was initiated on 10/3/24. Resident 2 was admitted to the facility on [DATE]. a. Review of Resident 2's Plan of Care revised on 9/12/24, showed a care plan problem addressing Resident 2's impaired skin integrity present on admission as evidenced by the Stage 2 pressure injury to the coccyx. Review of Resident 2's Wound Physician's Progress Note dated 9/25/24, showed Resident 2 had the Stage 3 coccyx pressure injury. Review of Resident 2's Order Summary Report showed a physician's order dated 9/25/24, to cleanse the coccyx pressure injury with normal saline, pat dry, apply Santyl ointment (wound treatment medication) and collagen powder and cover with a dry dressing once daily. Further review of Resident 2's Plan of Care failed to show the care plan was revised to address Resident 2's Stage 3 coccyx pressure injury. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/4/24 at 1517 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 verified the wound care physician classified Resident 2's coccyx wound as Stage 3 pressure injury on 9/25/24. LVN 1 verified Resident 2's care plan was not revised to address Resident 2's Stage 3 coccyx pressure injury. b. Review of Resident 2's Order Summary Report showed a physician's order dated 9/25/24, to cleanse the coccyx pressure injury with normal saline, pat dry, apply Santyl ointment (wound treatment medication) and collagen powder, and cover with a dry dressing daily. On 10/3/24 at 1111 hours, a wound care treatment observation was conducted with LVN 1. The treatment cart was observed with two boxes of Santyl medication. LVN 1 was observed writing an open date of 9/25/24, on one of the Santyl boxes. LVN 1 stated she was aware she was supposed to write the date when she opened the medication. LVN 1 then squeezed a Santyl medication into a plastic medication cup, prepared the rest of the wound care supplies, and proceeded to do the wound treatment for Resident 2. After LVN 1 provided the wound treatment to Resident 2, LVN 1 was asked which Santyl medication was used for Resident 2's wound treatment. LVN 1 verified she used the Santyl medication that she had just labeled with the date of 9/25/24; however, the Santyl medication label showed Resident A's name on it. LVN 1 verified the Santyl medication she used did not belong to Resident 2. LVN 1 stated each resident had their own medication. LVN 1 acknowledged the potential of contamination or wrong dosage when a medication used belongs to another resident.