

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555344	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER Bruceville Terrace - D/P Snf of Methodist Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 8151 Bruceville Road Sacramento, CA 95823	

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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43247</p> <p>Based on interview, record and policy review, the facility failed to follow their policy and procedure to conduct an initial skin assessment upon admission for one of four sampled residents (Resident 1) when Resident 1's admission skin assessment was not completed until the day after admission.</p> <p>This failure had the potential for a DTPI (Deep Tissue Pressure Injury- an injury that occurs when pressure damages the soft tissue beneath the skin surface, but there is no open wound) on the sacrum (base of the spine) to not be identified upon admission causing a delay in intervention and treatment.</p> <p>Findings:</p> <p>A review of Resident 1's Admission History LTC [Long Term Care], dated 4/2/24, indicated Resident 1 was admitted to the facility on [DATE] at 6:30 p.m. for right femur fracture [broken thigh bone] with surgical repair and had other multiple diagnoses including protein calorie malnutrition (deficiency of protein and other nutrients), diabetes (too much sugar in the blood), and chronic kidney disease (loss of kidney function, kidneys unable to filter blood the way they should).</p> <p>A review of Resident 1's skin assessment in the acute care hospital from 4/1/24 to 4/2/24, indicated a blanchable redness on the buttock. Another skin assessment dated [DATE] at 4:00 p.m., indicated, Resident 1's blanchable redness on buttock was unchanged.</p> <p>A review of Resident 1's Initial Assessment, dated 4/2/24 at 6:40 p.m., then signed on 4/3/24, indicated . Sacrum DTPI w/ [with] purplish discoloration .</p> <p>A review of Resident 1's Nursing Progress Note, dated 4/2/24 at 7:54 p.m., indicated .scattered bruising noted on R [right] leg, L [left] and R arm, pelvic area. Surgical site on R hip dressing dry and intact . Note did not indicate identification of DTPI to sacral area.</p> <p>A review of Resident 1's Progress Note Wounds, dated 4/3/24 at 9:00 a.m., indicated;</p> <p>.Wound Category: Pressure Injury</p> <p>Present on Admission-Wound: Yes</p> <p>Wound Stage: Deep Tissue Pressure Injury</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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Wound Photo Date: 4/3/2024 .</p> <p>A review of Resident 1's Wound Care Note, dated 4/3/24 at 2:11 p.m., indicated .admitted .on 4/2/24 .DTPI on sacrum, POA [present on admission], intact skin with localized area of persistent non blanchable deep red, maroon, purple discoloration .</p> <p>A review of Resident 1's physician order dated 4/3/24 indicated, Low Air Loss [designed to distribute the body's weight over a surface and help prevent skin breakdown], [Resident 1] has DTPI on sacrum upon admission .</p> <p>A review of Resident 1's Resident Care Team Meeting, dated 4/22/24, indicated .Patient admitted with pressure ulcer-deep tissue .</p> <p>During a concurrent interview and record review on 7/11/24 at 9:09 a.m. with the Director of Nursing (DON), the DON stated that Resident 1 was admitted to the facility on [DATE] with the sacral wound. Reviewed picture of sacral wound taken on 4/3/24. The DON stated that Resident 1 had a purple area on sacrum and the first time the wound was seen was 4/3/24. The DON stated the skin assessment was done the next morning on 4/3/24 by the wound nurse after admission on 4/2/24. The DON stated, We have 24 hours after admission to complete the skin assessment. The DON checked Resident 1's Discharge Summary from the acute care hospital on 4/2/24 and there was no documentation of Resident 1's DTPI on the sacrum. The DON stated a low air loss mattress was ordered on 4/3/24, staff were using a waffle cushion in wheelchair, and it was the expectation that Resident 1 was turned and repositioned every two hours, but it was not documented.</p> <p>During an interview on 7/11/24 at 12:25 p.m. with the Wound Nurse (WN), the WN stated Resident 1 had DTPI on the sacrum upon admission. WN stated that she did the wound treatments daily for Resident 1 and family was aware of wound progression as they were at bedside daily.</p> <p>A review of the facility's Policy and Procedure (P&P), titled [Name of facility] Pressure Injury Prevention and Treatment, dated 5/1995, indicated .Definition of Pressure Injuries .Deep Tissue Pressure Injury: Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister .Protocol for Skin and Wound Assessment .Assessment Schedule .Initial assessment of skin and wound condition is performed by the assigned LVN [Licensed Vocational Nurse]/ RN [Registered Nurse] at time of admission, and documented on the Admission Assessment form located in the patient ' s paper chart and in the Electronic Medical Record (EMR) .</p>