STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555350	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Grove Post Acute	1618 Laurel Avenue Redlands, CA 92373

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** 44262 Based on interview and record review the facility failed to prevent a pressure ulcer (damage to area of the skin due to pressure) from developing for one of three sampled residents (Resident 1). This failure placed a clinically compromised Residents (Resident 1) health and safety at risk for potential infection and pain. When the facility failed to prevent the development of a stage 3 pressure ulcer on right trochanter (hip). Findings: During review of Residents 1's Admission Record (general demographics), the document indicated Resident 1 was admitted to the facility on [DATE], with diagnoses to include: esophageal cancer (cancer of the tube from throat to stomach), tracheostomy (tube inserted to help oxygen reach lungs), (diabetes type II (body does not produce enough insulin, or resist insulin), hypertension (high blood pressure). During a review concurrent interview and record review of Resident 1's Medical Record with the Assistant Director of Nurses (ADON and Treatment Nurse (TXT Nurse), reviewed as follows: 1. Skin Pressure Injury Evaluation- Dated June 06, 2024, at 1307: Right Knee Stage 4, measuring 0.5x0.8, depth 0.2. (on admission). 2. Skin non pressure injury evaluation dated June 15, 2024: Right trochanter hip blanchable redness, length 5x4, depth none .Doctor notified, encourage patient to reposition as tolerated, pain management . 3. Skin Pressure Injury Evaluation dated June 19, 2024, at 1430: Right trochanter stage 3, measuring 1.5x1. 5, 0.1 depth .Reported by staff of resident with skin break down, noted the following. Right trochanter stage 3 pressure injury, tissue quality 100% granulation, scant serosanguinous drainage noted, wound edges well defined peri wound clean and intact. Resident noted to be noncompliant and is also noted to be favoring right side . (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	4. Carplan: The resident has pressure ulcer or potential for pressure ulcer development related to, unavoidable factors .Date initiated August 27, 2024. INTERVENTIONS: If the refuses treatment . Interdisciplinary Team (IDT) meeting and family to determine why and try alternative methods to gain compliance. Document alternative methods. (No Careplan regarding resident refusal for repositioning; facility acquired wound started June 19, 2024, no careplan documentation for June 2024, NO IDT meeting in June 2024 regaining wound and repositing refusals). During concurrent interview and record review on August 27, 2024, with the Treatment Nurse (TXT Nurse 1) of medical records, TXT nurse states, the pressure injury developed June 19, 2024, the right trochanter stage 3. The doctor wrote unavoidable factors. We reposition with pillows to keep him from going to right side. He was on air loss mattress. He had foley cath. When asked, should this resident have developed this Pressure injury in facility? States, No, he should have not, we were always repositing him, he was always favoring that side, we would let the CNAs and charge nurses know about repositioning this resident. During concurrent interview and record review on August 27, 2024, with the (ADON) of medical records, ADON nurse states, The family was at bedside, they knew about the wounds. Resident 1 was sent out to hospital a few times; he did come back with wounds. Based on the records he was first sent out June 23, 2024. The wound did develop in facility June 19, 2024, before he was sent out to hospital. (acknowledgement right trochanter developed in facility). During a review of the facility's policy and procedure titled, Wound Care dated January 01, 2024, the policy and procedure indicated, The purpose of this procedure is to assist the facility in the care, services and documentation related to the occurrence, treatment, and prevention of pressure as well as, non-pressure related wounds. During a review of the facility's policy and procedure titled, Prevention of Pressure Ulcers/Injuries dated January 01, 2024, the policy and procedure indicated, The purpose of this procedure is to provide information regarding identification of pressure ulcer/injury risk factors and interventions for specific risk factors. Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable.