STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555433	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastern Plumas Hospital- Portola Campus Dp/Snf	500 First Street Portola, CA 96122

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43739 Based on interview and record review, the facility failed to ensure that the Minimum Data Set (MDS, a standardized resident assessment) accurately reflected the status of two of three sampled residents (Resident 1 and 3) when the skin assessments did not accurately reflect their skin status. This failure had the potential for staff to not be fully informed of the residents ' health status to determine the need for further assessment and care interventions. Findings: During a review of the facility ' s policy titled, Minimum Data Set and Resident Assessment Instrument Process, revised 5/2022, indicated, It ' s the policy of this facility to complete the Resident Assessment Instrument (RAI) and/or the Minimum Data Set (MDS) in accordance with the utilization guidelines set forth in Federal regulations. During a review of Long -Term Care Facility Resident Assessment Instrument 3.0 User ' s Manual, version 1. 18.11, updated 10/2023, indicated: 1. The Long-Term Care Facility Resident Assessment Instrument User ' s Manual for Version 3.0 is published by the Centers for Medicare & Medicaid Services (CMS) and is a public document. 2. The purpose of this manual is to offer clear guidance about how to use the Resident Assessment Instrument (RAI) correctly and effectively to help provide appropriate care. 3. The RAI helps nursing home staff gather definitive information on a resident ' s strengths and needs, which must be addressed in an individualized care plan. It also assists staff with evaluating goal achievement and revising care plans accordingly by enabling the nursing home to track changes in the resident ' s status. 4. The RAI consists of three basic components: The Minimum Data Set (MDS) Version 3.0, the Care Area Assessment (CAA) process and the RAI Utilization Guidelines. The utilization of the three components of the RAI yields information about a resident ' s functional status, strengths, weaknesses, and preferences, as well as offering guidance on further assessment once problems have been identified. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
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F 0641

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

5. Minimum Data Set (MDS). A core set of screening, clinical, and functional status data elements, including common definitions and coding categories, which form the foundation of a comprehensive assessment for the residents of nursing homes.

6. The Resident Assessment Instrument (RAI) Manual offers clear guidance on how to complete the MDS correctly and effectively. The RAI helps nursing home staff gather definitive information on a resident ' s strengths and needs, which must be addressed in an individualized care plan.

7. The RAI Version 3.0 Manual, Section L, skin condition, indicated, it ' s to document the risk, presence, appearance, and change of pressure ulcers as well as other skin ulcers, wounds or lesions. Also includes treatment categories related to skin injury or avoiding injury.

Resident 1

During a review of Resident 1 ' s medical record, indicated that Resident 1 was admitted to the facility's Loyalton campus on 9/23/24 with diagnoses which included Alzheimer ' s disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities) without behavioral disturbance, personal history of (healed) traumatic fracture. Resident 1 was transferred to Facility's Portola campus on 1/30/25. Resident 1 was not her healthcare decision maker.

During a review of Resident 1 ' s Admission Minimum Data Set (MDS - an assessment and care screening tool), dated 10/3/24, in the section M - Skin conditions, the MDS indicated that Resident 1 did not have a pressure ulcer/injury, a scar over bony prominence, or unhealed pressure ulcers/injuries.

During a review of Resident 1 ' s most recent MDS, dated [DATE], the MDS indicated that Resident 1 had a brief interview for mental status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 3 out of 15, indicating her cognition was severely impaired.

During a concurrent interview and record review on 3/10/25 at 9:45 am with the MDS Registered Nurse (MDS RN), the MDS RN confirmed that Resident 1 ' s MDS, dated [DATE], completed by RN G, in the section M -Skin, the MDS indicated that Resident 1 was not at risk of developing pressure ulcers/injuries. The MDS RN stated, I did not do Resident 1 ' s admission MDS. RN G who did it was retired. MDS RN stated that Resident 1 was clearly at risk of developing pressure ulcer, and she did not have an answer as to why RN G marked it as No. MDS RN also stated that Once a resident was marked as at risk of developing pressure ulcer in MDS, the pressure ulcer prevention care plan would be initiated. The MDS RN confirmed the Resident 1 did not have pressure ulcer prevention care plan developed when she was admitted .

During a concurrent interview and record review on 3/10/25 at 10 am with DON A, Resident 1 ' s record was review. The DON A confirmed that there was a discrepancy in which RN G marked Resident 1 was not at risk of developing pressure injury in Resident 1 ' s MDS, dated [DATE], but RN G assessed Resident 1 with a score of 18 at BRADEN Scale for Predicting Pressure Ulcer Risk (a tool used to assess a patient's risk of developing pressure injuries), dated 10/15/24, indicating Resident 1 was at risk for developing pressure ulcer.

Resident 3

(continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 3 ' s medical record, indicated that Resident 3 was admitted to the facility on [DATE] with diagnoses which included quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury). Resident 3 was diagnosed with pressure ulcer (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) of right buttock, and pressure ulcer of left buttock on 12/9/24. Resident 3 was not her healthcare decision maker. During a review of Resident 3 ' s most recent Minimum Data Set, dated dated [DATE], the MDS indicated that Resident 3 had a BIMS score 15 out of 15, indicating Resident 3 was cognitively intact. During a concurrent interview and record review on 3/10/25 at 10 am with DON A, Resident 3 ' s MDS, dated [DATE], completed by RN G, was reviewed. In the section M - Skin conditions, the MDS indicated that Resident 3 did not have a pressure ulcer/injury, a scar over bony prominence, or unhealed pressure ulcers/injuries, the MDS also indicated that Resident 3 did not have one or more unhealed pressure ulcers/injuries. The DON A confirmed that Resident 3 had been diagnosed with pressure ulcers on his buttocks since 12/9/24 and was still under the treatment. The DON A confirmed that Resident 3 ' s MDS assessment was inaccurate.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43739 Based on observation, interview, and record review, the facility failed to provide the necessary care and services to ensure that a resident ' s needs and choices for personal hygiene - oral care were met for two of three sampled residents (Resident 1 and 2) when, Yellow thickened substance on the surface of the tongue of Resident 1 and 2. Resident 1 was observed to have the food from the day before stuck in between her teeth and on her tongue. Resident 2 was observed to have blue cake that she ate the night before smearing around her mouth. This deficient practice had the potential to adversely affect the resident's psychosocial well-being by not receiving hygiene and feeling dirty. Findings: Resident 1 During a review of Resident 1 ' s medical record, indicated that Resident 1 was admitted to the facility's Loyalton compus on 9/23/24 with diagnoses which included Alzheimer ' s disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities) without behavioral disturbance, personal history of (healed) traumatic fracture. Resident 1 was transferred to the facility's Portola on 1/30/25. Resident 1 was not her healthcare decision maker. During a review of Resident 1 ' s most recent Minimum Data Set (MDS - an assessment and care screening tool), dated 1/2/25, the MDS indicated that Resident 1 had a brief interview for mental status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 3 out of 15, indicating her cognition was severely impaired. During a review of Resident 1 ' s most recent MDS, dated [DATE], at the section GG (a section which stands for Functional Abilities and Goals; it specifically assesses a patient's ability to perform self-care tasks and mobility activities, including their admission performance, discharge goals, and how much assistance they require for these functions), the MDS indicated that Resident 1 needed maximal assistance (the staff does more than half the effort) from the staff for her oral hygiene (the ability to use suitable items to clean teeth.) During an interview on 2/10/25 at 3:35 pm, with Family C, the Family C stated that she had visited Resident 1 while she was resided in Facility L and had never seen the staff provided personal hygiene for Resident 1. The Family stated, I saw food stuck in between her teeth and on her tongue. There were some yellowish buildups on the top of the tongue. It was really gross! It ' s like they had never cleaned her teeth for month. Resident 2 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 2 ' s medical record, indicated that Resident 2 was admitted to the facility on [DATE] with diagnoses which included Alzheimer ' s disease, dementia without behavioral disturbance, weakness. Resident 2 was not her healthcare decision maker. During a review of Resident 2 ' s most recent Minimum Data Set, dated dated [DATE], the MDS indicated that Resident 2 had a BIMS score of 99, indicating Resident 2 was unable to complete the interview. During a review of Resident 2 ' s most recent MDS, dated [DATE], at the section GG, the MDS indicated that Resident 2 refused oral hygiene. During a review of Resident 2 ' s Activities of Daily Living (ADL) care plan, the care plan indicated that Resident 2 had an ADL self-care performance deficit related to activity intolerance, aggressive behavior, Alzheimer ' s, confusion, dementia, and the goals were that Resident 2 Will be clean, well-cared for, well groomed, nourished and comfortable through the review date. The intervention did not indicate a plan when Resident 2 refused her oral care. During a concurrent observation and interview on 2/11/25 at 10:32 am, in Resident 2 ' s room, Resident 2 was observed lying in bed awake. Resident 2 was observed with her mouth open which exposed the tongue with thick yellowish substance. Observed a small bottle of water (100 milliliter) placed on the bedside table that was positioned near the end of Resident 2 ' s bed. When asked, Resident 2 was able to state her first name, and stating that she was not thirty at this moment, but she did not know how to get the water bottle when she was thirty because it was far from her reach. Resident 2 was not able to locate the call light. During an interview on 2/11/25 at 12:13 pm, with Director of Nursing (DON)A. The DON A stated Facility L did not have ADL policy, and Certified Nursing Assistant (CNA) provided ADL for the residents. The expectation was the CNA had to provide the ADL service at each shift, which meant that oral care had to be provided at least two times a day. If the resident refused the care, they would notify the nurse, and the nurse would document it, and the service would be offered to the resident again. If the resident continued refusing it, it would then be documented as Refusal. During a concurrent interview and record review on 2/11/25 at 12:27 pm, with CNA F, Resident 1 and 2 ' s ADL sheets - oral care record, from 10/10/24 to 1/30/25, were reviewed. The CNA F confirmed that there was a total of 22 shifts that indicated Resident 1 did not receive oral care. The CNA F also confirmed that Resident 2 ' s oral care record was not accessible for unknow reason. The CNA F stated, Ya, the travelers (a CNA who takes on temporary assignments in various healthcare facilities) did not do ADL. During a concurrent interview and record review on 2/11/25 at 1:39 pm, with DON A, Resident 1 and 2 ' s ADL sheets - oral care record, from 10/10/24 to 1/30/25, were reviewed. The DON A confirmed that there was several days missing on the ADL sheet - oral care record for Resident 1, and she was also unable to access Resident 2 ' s ADL - oral care record. (continued on next page)

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Facility ' s job posting website titled, CNA Full time - Days/Nights, dated 2/27/25, indicated the principal accountabilities for CNA were: .Provides morning care, which may include bed bath, shower or tub bath, oral hygiene, combing hair, back care, dressing residents, changing bed linen, cleaning over the bed table and bedside stand, straightening room and other general care as necessary throughout the day . Provides evening care which includes hands/face washing as needed, oral hygiene, back rubs, perineal care, freshening linen, cleaning over the bed tables, straightening room and other general care as needed . During an interview on 3/10/25 at 11:29 am with CNA F, the CNA F stated, I had noticed that some oral care did not get done. We could tell by seeing the Buildup on the residents ' teeth, like some food from yesterday . the CNA F stated that she had seen food stuck in Resident 1 ' s teeth and on her cloth when CNA F started the day shift. The CNA F said, I did not report it to anyone, I just cleaned it up. The CNA F stated the night shift also need to provide oral care, But I don ' t think they did it! I reported it to the nurses, they said they would pass it on. During an interview on 3/10/25 at 12:45 pm, with CNA K, the CNA K stated she found it happened very often in which residents ' teeth not been cleaned and found food on the residents ' teeth. The CNA K stated, The night shift did not provide oral care. Last Tuesday was Shrove Tuesday, we celebrated it with the residents. The residents were having blue cake that night. Next morning, when I came in, all my assigned residents (10 residents), including Resident 2, had blue color around their mouths. I reported it to the Assistant Director of Nursing, I did not know what happened after.

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(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** 43739 Based on interview and record review, the facility failed to follow up on an identified pressure ulcer (localized damage to the skin and/or underlying soft tissue usually over a bony prominence, where bones are close to the surface of the skin), to evaluate, and intervene in a timely manner to prevent an avoidable pressure ulcer for one of three residents (Resident 1) sampled for pressure ulcers. This resulted in Resident 1 developing a 1-centimeter (cm) x 1.25 cm pressure ulcer on her left heel. Findings: During a review of National Pressure Injury Advisory Panel (a global driver of quality improvement and patient safety in health care) website newsletters titled, Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline, updated 2/25/25, indicated: A pressure injury is localized damage to the skin and/or underlying soft tissue, usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. Stage 1 Pressure Injury: Non-blanchable erythema of intact skin - Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature or firmness may precede visual changes. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis - Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may represent as an intact or ruptured serum-filled blister. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon, or purple discoloration - Intact or non-intact skin with localized area or persistent non-blanchable deep red, maroon, purple discoloration, or epidermal separation revealing a dark wound bed or blood-filled blister. Pressure injury prevention and treatment requires multi-disciplinary collaborations, good organizational culture and operational practices that promote safety. Per the International Guideline, risk assessment is a central component of clinical practice and a necessary first step aimed at identifying individuals who are susceptible to pressure injuries. Other interventions that influence an individual's healing process may include identifying nutritional needs, repositioning and early mobilization, skin care, use of support surfaces, cleansing and debridement, pain assessment and management, psychological and spiritual support, and family support. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Skin care - Protecting and monitoring the condition of the patient's skin is important for preventing pressure sores and identifying Stage 1 sores early so they can be treated before they worsen: Inspect the skin upon admission and at least daily for signs of pressure injuries; Assess pressure points, temperature, and the skin beneath medical devices; Clean the skin promptly after episodes of incontinence, use skin cleansers that are pH balanced for the skin, and use skin moisturizers; Avoid positioning the patient on an area of pressure injury. Positioning and Mobilization - Turn and reposition at-risk patients, if not contraindicated; Plan a scheduled frequency of turning and repositioning the patient; Consider using pressure-relieving devices when placing patients on any support surface; Consider the patient's body size, level of immobility, exposure to shear, skin moisture and perfusion when choosing a support surface. During a review of Resident 1's medical record, indicated that Resident 1 was admitted to the Loyalton campus on 9/23/24 with diagnoses which included Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities) without behavioral disturbance, personal history of (healed) traumatic fracture. Resident 1 was transferred to the facility's Portola Campus on 1/30/25. Resident 1 was not her own healthcare decision maker. During a review of Resident 1's Admission Minimum Data Set (MDS - an assessment and care screening tool), dated 10/3/24, in the section M - Skin conditions, the MDS indicated that Resident 1 did not have a pressure ulcer/injury, a scar over bony prominence, or unhealed pressure ulcers/injuries. During a review of Resident 1's most recent MDS, dated [DATE], indicated that Resident 1 had a brief interview for mental status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 3 out of 15, indicating her cognition (ability to think and reason) was severely impaired. During a review of Resident 1's most recent MDS, dated [DATE], section GG (a section which stands for Functional Abilities and Goals; it specifically assesses a patient's ability to perform self-care tasks and mobility activities, including their admission performance, discharge goals, and how much assistance they require for these functions), indicated that Resident 1 needed maximal assistance (the staff does more than half the effort) from the staff for her mobility (the ability to move or be moved freely and easily). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and review of Resident 1's medical record with the Director of Nursing (DON) A on 2/11/25 at 1:39 pm, DON A stated that she did not know when Resident 1 started developing the pressure injury on the left heel. DON A confirmed that Resident 1's progress note, dated 12/6/24 at 6:36 pm, written by Licensed Nurse (LN) D, indicated that LN D wrote She [Resident 1] had an old area on her left heel. We are going to watch the area and make sure we float her feels when she is in the bed. DON A confirmed that LN D initiated a care plan on 12/6/25 for Resident 1's left heel lesion, the plan indicated, Left heel has a hard black callous, and the interventions were to, Float her heels while she is in the bed; monitor for signs of infection; notify the MD if becoming infected or becomes open; perform any treatments that are ordered by medical provider; use the booties for her feet while she is in the bed. The DON A confirmed that there was no record indicating that the staff were floating the Resident1 's heel and applied the booties as indicated on the care plan. DON A confirmed that the Care Conference, held on 1/8/25 at 9:44 am, in the section of Nursing Summary, indicated that Resident 1's Responsible Party (RP) Was concerned over her [Resident 1] decline She [Resident 1] also has a pressure injury to her left heel. She doesn't like to converse much anymore. She requires more care and participates less in her cares DON A also confirmed that there was no plan/intervention initiated to treat Resident 1's pressure injury after the meeting. DON A confirmed that the Care Conference, held on 1/22/25 at 12:02 pm, in the section of Nursing Summary, indicated that the family Expressed concern about a sore on her [Resident 1] left heel . DON A confirmed that the physician was then notified, and wound care order was obtained on 1/22/25 after this care conference. A delay of 47 days after the wound was identified by LN D on 12/6/24. During an interview on 3/6/25 at 2:11 pm, Family Member (FM) C confirmed that Resident 1 did not have any skin lesion before Resident 1 was admitted to the facility. The FM C stated, I wanted to say I found that sore two weeks before she [Resident 1] was transferred to another facility, right around Christmas. It was always wrapped with bandage. I had asked before when I came in, and she was not wearing her shoes, no shocks. They said, 'Ya, that happened'. During a concurrent interview and record review on 3/10/25 at 9:45 am with the MDS Registered Nurse (MDS RN), the MDS RN confirmed that Resident 1's MDS, dated [DATE], completed by RN G, in the section M -Skin, the MDS indicated that Resident 1 was not at risk of developing pressure ulcers/injuries. The MDS RN stated, I did not do Resident 1's admission MDS. RN G who did it was retired. MDS RN stated that Resident 1 was clearly at risk of developing pressure ulcer, and she did not have an answer as to why RN G marked it as No. MDS RN also stated that Once a resident was marked as at risk of developing pressure ulcer in MDS, the pressure ulcer prevention care plan would be initiated. The MDS RN confirmed the Resident 1 did not have pressure ulcer prevention care plan developed when she was admitted . During a concurrent interview and record review on 3/10/25 at 10 am with DON A, Resident 1's record was reviewed. DON A confirmed that there was a discrepancy in which RN G marked Resident 1 was not at risk of developing pressure injury in Resident 1's MDS, dated [DATE], but RN G assessed Resident 1 with a score of 18 at BRADEN Scale for Predicting Pressure Ulcer Risk (a tool used to assess a patient's risk of developing pressure injuries), dated 10/15/24, indicating Resident 1 was at risk for developing pressure ulcers. (continued on next page)

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F 0686

Level of Harm - Actual harm

Residents Affected - Few

During a concurrent interview and record review on 3/10/25 at 10:45 am, with DON A, and LN D. LN D recalled that Resident 1 did not have any skin issue when she assessed Resident 1 during admission assessment on 9/23/24. The LN D stated, When Resident 1 had a bowel movement on 12/6/24, I assisted the Certified Nursing Assistant (CNA) to clean up Resident 1. The CNA told me, 'Did you see that?' I then saw a black, and dry blister about the size of 2 cm X 2 cm on Resident 1's left heel. I talked to the RP and reported it to the DON A, the DON A said, 'document it', so I did, and care planned it. I did not report it to the physician because it was dry. The LN D confirmed that Resident 1's care plan indicated, floating feet, however, there was no floating feet task initiated to indicate the staff was providing such service to Resident 1. LN D stated, We just started PCC (a software platform used to manage and streamline various aspects of facility operations, including resident care, documentation, and billing) in September 2024. No one was checking whether Resident 1's feet were floated or not. The DON A agreed and said, we should have better communication on the wound care.

During a concurrent interview and record review on 3/10/25 at 12:14 pm, with DON A, LN D and LN E, a facility's document titled, Alert Charting - for changes in condition, dated 12/2024, was reviewed. Resident 1's name appeared on the record, dated 12/6/24, the reason for Resident 1 on alert charting was blackened area on L heel highlighted in yellow. Both LN D and E stated that this Alert Charting was how the nursing staff documented the wound care/condition and gave report to the next shift. They admitted that they did not document/update the wound condition in the resident's progress note, or weekly skin assessment. Both LNs agreed that there was no wound assessment on the alert chart, and there was no way to know Resident 1's wound condition such as the stage, the size, the color, any discharge, etc. since the nursing staff did not document it anywhere else. The LN E stated, I was never told that I have to document the wound condition in the weekly skin assessment. The DON A stated the facility did not have skin assessment, wound care, or pressure ulcer policy because the facility did not have wound care nurse, and did not provide wound care training even though the facility had been providing wound care service to the residents, the DON A said, We don't need it, we just looked it up online. The DON A stated that someone cancelled Resident 1's alert charting on 12/9/24 and highlighted it in yellow. She said, When an alert charting - change condition was resolved, we highlighted it to indicate that it's resolved. I believe that was why Resident 1's pressure sore was missed. We did not know who marked it, but it's too late now!

During a concurrent interview and record review on 3/10/25 at 2:31 pm with DON B, in the Portola campus, Resident 1's admission progress note was reviewed. DON B stated Resident 1 was transferred from the Loyalton campus to her facility (Portola campus) on 1/30/25, she said, Resident 1 came with a pressure ulcer on her left heel, it was measured 1 cm X 1.25 cm. DON B stated, We have a wound management policy. The Loyalton and Portola campuses are both distinct part skilled nursing facilities of the same hospital, so we [Loyalton Campus and Portola campus] share the same policy. DON B confirmed that the Wound Management policy, revised 2/2022, indicated:

It is the policy of the facility to follow guidelines for the preservation of skin, prevention of skin disruption and the identification, assessment, appropriate treatment and documentation of injuries to the skin including, but limited to, wounds.

Assessment should: be done and documented daily .; should include alteration or disruptions of the skin, paying special attention to bony prominences and areas of increased moisture, pressure of sheering; include a skin risk assessment by using the Braden Scale Assessment in admission assessment or shift assessment in the electronic medical record.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
NAME OF PROVIDER OR SUPPLIER: Eastern Plumas Hospital- Portola Campus Dp/Snf		STREET ADDRESS, CITY, STATE, ZIP CODE: 500 First Street, Portola, CA 96122	

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	Documentation should include wound base; wound drainage; wound odor, wound edges; pain; edema; pulses; staging of wound (only if the wound has been determined to be caused by pressure) - refer to Medline Wound and Skin Care Reference Guide in Wound Care to stage wound. Interventions - wounds should be managed as soon as they are identified. Notify the overseeing provider. Contact Physical Therapy or a Certified Wound Nurse for a consultation, if available and as directed by the overseeing provider.