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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555435	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reche Canyon Regional Rehab Center	1350 Reche Canyon Rd Colton, CA 92324

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44262 Based on observation, interviews, and record review the facility failed to ensure 1 of 3 sampled residents (Resident 1), was provided proper wound care treatments and assessment. This failure placed a clinically compromised Resident (Resident 1) health and safety at risk. When skin integrity was not being treated and assessed by nursing staff that resulted in infection and hospital stay. 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: acute kidney failure (kidneys lose ability to remove waste), heart failure (heart doesn't pump blood as well), osteomyelitis to left ankle and foot (inflammation of bone caused by infection), diabetes type II (body does not produce enough insulin, or resist insulin), hypertension (high blood pressure). During a concurrent interview and record review of Resident 1's Medical Record with the Assistant Director of Nursing (ADON) reviewed and verified the following: 1. Treatment Administration Record (TAR) August 2024: 1.Left Flank: [NAME] -[NAME] (JP) (surgical suction drain) drain site, cleanse with normal saline, pat dry then cover with bordered dressing every day for 21 days. (signed off as completed). 2.Left flank side incision with staples: cleanse with normal saline, pat dry and apply triple antibiotic ointment then leave open to air daily for 21 days. (signed off as completed). 3.Left thigh: skin graft (donor site) monitor for signs and symptoms of infection wait for Xeroform to dry and slough off every day for 21 days. (signed off as completed). 4.Scalp: Skin graft site: cleanse with normal saline, pat dry, apply Xeroform then leave open to air every day for 21 days. (signed off as completed). On interview, Treatment Nurse states, wound care was not provided due to resident refusals for 3 days. (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: 555435	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Careplan (wound care refusal): Careplan (wound care refusal): has behavior problem refusing treatment on the Left flank/thigh and at risk for further wound decline or infection .yelling that hospital told resident for nurses not to touch dressing except dressing on scalp .Administer medications as ordered. Monitor/documents for side effects and effectiveness. Teach the risk and benefits of refusing treatment as ordered .encourage to allow staff to complete wound dressing on .MD notified. 3. No documentation in Progress notes of resident wound treatment refusal, no follow up assessment notes, no education, no documentation of doctor notification in progress notes and a follow up call to notify physician refusal of 3 days. During concurrent interview and record review on August 07, 2024, with the Treatment Nurse (TXT Nurse 1) of Medical records, TAR August 2024, TXT nurse states, I took care of Resident 1 August 2nd ,3rd and 4th and he had no issues with his surgical sites. On the August 02, 2024, I tried to check the wound, he told me no and refused the treatment. For the JP drainage, I just looked at the site, there was no infection. But he did not let me change the dressing for the 3 days I had him, only looked at it. The JP drain, he did allow us to drain it and the amount was documented. For the left flank with staples, I just observed it because he did not allow me to touch it. He did not allow me to apply the antibiotic ointment. He was fully alert, he was not confused. For the 3 days I had him, I did not do the wound treatments I just did observation and output the JP drainage. I notified [name] Nurse Practitioner (NP) for doctor regarding the refusals, I care planed it and I did my notes there. I sent the NP a message, I didn't get anything back from him, I continued monitoring and endorsed to next shift. I did not document in progress note regarding the 3 days of refusal. I did not document that I called the doctor regarding the refusal. I only documented in Careplan. When asked, how would the oncoming nurse know what is going on with this resident, his refusal on surgical wound treatments if there are no Progress Notes on this issue? States, I endorsed to next shift. During an interview on August 07, 2024, with the DON, DON states, the (TXT Nurse 1) told me that the Resident 1 was screaming at them stating the hospital told me not to have anyone touch the dressing .we did a care plan of refusal and educate resident on risk and benefit. Resident 1 is currently still at hospital. The treatment nurse, she just did the care plan regarding resident refusing wound care treatment and it stated NP notified. There is no Progress Notes on resident refusal and education provided. She (treatment nurse) documented wrong on the TAR, she should have documented refused and provided a note instead of checking off as if treatment was done. She should not have documented the treatment was provided when it was not. There is no progress notes of the refusals or doctor notification of refusals. Its only care planed, it should have been documented and follow up continued care. I was not made aware this resident was refusing wound treatment for 3 days. During an interview on August 19, 2024, with the ADON, DON states, Resident 1 is still at the acute hospital, report is that resident is stable, reason he is still there is that he is on Intravenous antibiotics and [NAME] Blood Count (WBC) monitor. His WBC is out of range and they want to monitor the WBC, once he is ready they will send back to facility with documentation of hospital stay. During a review of the facility's policy and procedure titled, Wound Care revised October 2010, the policy and procedure indicated, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Documentation .the following should be recorded in the residents' medical record: 1. Wound care provided, 2. Date and shift the wound care was provided, 4. Any change in the resident's condition, 5. Assessment data. (continued on next page)

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