STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555463	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Village Healthcare Center	2400 West Acacia Avenue Hemet, CA 92545

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 - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40000 Based on observation, interviews, and record reviews the facility failed to ensure, for four of six residents reviewed (Residents A, B, C, and D), wound management to treat pressure ulcers (localized area of skin and tissue damage caused by prolonged pressure on the skin) was provided according to the plan of care, when: 1. For Resident A, there was no comprehensive assessment (indicating measurement, color, tissue appearance, presence of drainage, odor, appearance of surrounding tissue) of the re-opened sacral wound; 2. For Resident B, there was no comprehensive assessment of the wound on the bilateral buttocks upon admission. In addition, there was no weekly re-evaluation of the bilateral buttocks wound the week of September 18 to 20, 2024; 3. For Resident C, there was no treatment provided to the left buttock pressure ulcer. In addition, there was no comprehensive assessment of the left buttocks wound upon admission; and 4. For Resident D, there was no comprehensive assessment of the left buttocks pressure ulcer upon admission. In addition, there was no re-evaluation of the left buttock pressure ulcer on September 25, 2024. These failures had the potential to result in the identification of the resident ' s pressure ulcer condition and could delay appropriate care and treatment. Findings: On October 22, 2024, at 8:45 a.m., an unannounced visit to the facility was conducted to investigate two complaints of quality of care. On October 22, 2024, at 10:38 a.m., an interview was conducted with the treatment nurse (TN). The TN stated there were six residents being provided treatment for skin conditions. 1.On October 22, 2024, at 1:35 p.m., an observation and concurrent interview were conducted with the Treatment Nurse during provision of wound treatment to Resident A. The TN was observed to provide treatment to Resident A ' s necrotic wound on the right foot. The TN stated the treatment for the wound on the coccyx area was also provided earlier in the day. (continued on next page)

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 - Some	On October 22, 2024, a review of Resident A ' s medical record was conducted. Resident A was admitted on [DATE], with diagnoses which included ischemic infarction (mini stroke-a blood clot, blocks blood supply and oxygen) of muscle, right lower leg, peripheral vascular disease (PVD-a condition in the body in which narrowed blood vessels decrease blood flow to the limbs), and cellulitis (infection to the skin) of right lower leg. A review of Resident A's care plans, dated October 9, 2024, indicated Resident A has a pressure ulcer noted to coccyx, interventions included to measure wound upon admission or wound development and regularly thereafter, observe for compliance with turning and repositioning and inform MD (medical doctor) and document when non-compliance (failure to act in accordance with a wish/commend) is present, perform wound care as ordered, re-evaluate every 7-10 days and PRN (as needed). A review of Resident A's Treatment Nurse New Admission Risk Assessment, dated October 9, 2024, at 4:21 p.m., indicated .right foot .right dorsal foot all toes, diabetic ulcer with necrosis Right lateral knee diabetic ulcer Coccyx old/healed wound . There was no documentation to indicate measurements, a description of the wounds, drainage, or odor on the different wound sites. A review of Resident A's Treatment Nurse Weekly Skin Assessment, dated October 16, 2024, at 11:00 a.m., indicated, .Recurrent stage 4 (four) to sacrococcxy 3 x 2.6 x 0.4 (cm) (centimeter- unit of measurement) . No documentation of Resident A's skin re-opening and the development of a sacrococcyx stage four ulcer was found from Resident A's admitted d October 9, 2024, until October 18, 2024. A review of Resident A's Wound Consultant Progress Note, dated October 18, 2024, indicated, . sacrococcyx, sacral region .pressure ulcer stage 4 (four) .40% slough (dead tissue) .40% granulation/20% epithelial (healthy) tissue .exudate amount (minimal) .erythema (redness to skin) (mild); macerated (softening and break down of skin) (mild) .fat layer exposed .excisional debridement .full thickness .3.0 x 2.6 x 0.4 cm . On October 22, 2024, at 4:25 p.m., an interview was conducted with the TN. The TN stated she knows she should have measured Resident A's wounds on admission and monitor the wounds to track progression of the wounds to determine if it is healing or getting worse. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On October 24, 2024, at 9:30 a.m., an interview and concurrent record review was conducted with the TN, regarding Resident A. The TN stated she did not know when Resident A's healed sacrococcyx ulcer re-opened and became a stage four pressure ulcer, she stated she did not measure the wounds when the residents were admitted , and she would wait until the wound consultant sees the residents. The TN stated she did not re-assess Resident A's coccyx area prior to the wound consultant's visit on October 18, 2024, nor write a note or fill out a Change of Condition form after the stage four pressure ulcer to Resident A's coccyx area was discovered. The TN stated she based her weekly skin notes from the wound consultant notes. The TN stated she did not measure the wounds of Resident A on October 16, 2024. The TN stated she did not include a description of the wound bed, odor, amount of exudate or type in the weekly skin notes. The TN stated she did not complete the weekly skin note indicating the measurement or location of the wounds because it was too difficult. The TN stated the assessment of Resident A's sacrococcyx wound was conducted on October 18, 2024, but was documented as October 16, 2024, because it was the date the weekly skin note was due. The TN stated she did not complete a weekly skin note for Resident A on October 23, 2024, as indicated. The TN stated the scarred tissue on the sacrococcyx area was not monitored since admission on October 9, 2024, until October 18, 2024 (date the open wound at the sacrococcyx area was identified). 2. On October 22, 2024, at 11:50 a.m., a review of Resident B's medical record was conducted. Resident B was rea-admitted to the facility on [DATE], with diagnoses which included sepsis (infection in the blood) and diabetes mellitus (abnormal blood sugar). A review of Resident B's undated History and Physical Examination, indicated Resident B had the capacity to understand and make decisions. A review of Resident B's Treatment Nurse New Admission Risk Assessment, dated August 21, 2024, indicated, .incontinent of bowel and bladder .abdominal fold MASD (moisture associated skin damage-caused by prolonged exposure to moisture). Bilateral (both) buttocks MASD . The document did not include description (appearance, size, presence of drainange) of Resident B's MASD on the abdominal fold and bilateral buttocks. A review of Resident B's care plan, dated August 21, 2024, indicated, .At risk for further skin breakdown r/t (related to) Impaired bed mobility .Incontinence .Interventions .Apply barrier (provides the skin protection from irritants) cream as needed .observe for skin improvement or deterioration frequently .Provide prompt and thorough peri-care as needed and especially following episodes of incontinence .Provide treatment per MD (medical doctor) orders . A review of Resident B's Minimum Data Set (MDS - a resident assessment tool), dated October 18, 2024, indicated Resident B was always incontinent (unable to control) of bladder and bowel. A review of Resident B's Treatment Nurse Weekly Skin Assessment, dated August 28, 2024, indicated, .This form should be completed weekly on all residents per facility policy. Any areas of Skin requiring treatment should have a thorough record of documentation .Noted with MASD to bilateral buttock and abdominal folds . The document did not include description of Resident B's MASD on the bilateral buttocks. A review of Resident B's Wound Consultant Progress Note, dated August 29, 2024, indicated, .Left, Buttock . irritant contact dermatitis due to .dual incontinence (MASD) .No Wound Assessment .Superficial .Right, Buttock .No wound Assessment .Superficial . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident B's Treatment Nurse Weekly Skin Assessment, dated September 4, 2024, indicated, . The MASD to bilateral buttock ongoing . The document did not include description of Resident B's MASD on the bilateral buttocks. A review of Resident B's Wound Consultant Progress Note, dated September 6, 2024, indicated, .left, buttock .irritant contact dermatitis (rash) due to .dual incontinence (MASD) .4.0 x 2.0 x 0.2 cm .100% epithelial tissue .exudate (drainage) amount (minimal) .serosanguinous (blood and fluid) .non selective debridement (surgical removal of dead tissue) .Site 002 .right, buttocks .irritant contact dermatitis due to . dual incontinence (MASD) .2.0 x 2.0 x 0.2 cm (centimeters) .100% epithelial tissue .exudate amount (minimal) . serosanguinous .non selective debridement . A review of Resident B's Treatment Nurse Weekly Skin Assessment, did not include description of Resident B's MASD on the bilateral buttocks, on the following dates: - September 11, 2024; - September 18, 2024; - September 25, 2024; and - October 2, 2024; There was no documented evidence the TN conducted an assessment of the MASD on bilateral buttocks on October 9, 2024. Further review of Resident B's wound consultant progress note, indicated there was no documented assessment conducted by the wound consultant on September 20, 2024. There was no documented evidence a wound assessment of the MASD for Resident B's bilateral buttocks was conducted on the week of September 18 to 20, 2024, either from the treatment nurse or the wound consultant. On October 22, 2024, at 4:25 p.m., an interview was conducted with the TN. The TN stated she did not complete a Treatment Nurse Weekly Skin Assessment for Resident B's MASD on bilateral buttocks, dated October 9, 2024. The TN stated she should have measured the wounds of the residents on admission and weekly to track progress of the wound and to determine if it was healing or getting worst. 3. On October 24, 2024, a review of Resident C's medical record was conducted. Resident C was admitted to the facility October 9, 2024, with diagnoses which include altered mental status and pressure ulcer of left buttock, stage three. A review of Resident C's Treatment Administration Record (TAR), dated October 2024: - .Left buttocks stage III (three), clean with NS, apply triple ATB (antibiotic) ointment, pack with collogen [sic] powder followed by calcium alginate, cover with dry dressing every day shift, start date 10/10/2024 (October 10, 2024) . There was no documentation for treatments were completed on October 10, 2024, October 11, 2024, and October 18, 2024. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- .Left buttocks stage III (three), clean with NS, pack with collogen [sic] powder followed by calcium alginate, cover with dry dressing. Zinc to peri-wound every day shift ., start date October 19, 2024, no documentation for treatment were completed on October 23, 2024. A review of Resident C's care plans: - dated October 9, 2024, indicated Resident C was at risk for impaired skin integrity-presence of ulcer stage three, interventions included monitor for signs or symptoms of redness, drainage, fever, foul odor, or purulent (infected discharge from wound) drainage and inform MD if noted, observe for skin improvement or deterioration, provide prompt and thorough peri-care as needed; - dated October 17, 2024, indicated Resident C was at risk for skin breakdown r/t impaired bed mobility, incontinence, admitted with stage 3 pressure ulcer to left buttocks, interventions included observe for skin improvement or deterioration frequently, teach resident about risk factors for developing a pressure ulcer and the healing process once one develops. A review of Resident C's Treatment Nurse New Admission Risk Assessment, dated October 10, 2024, at 3:45 p.m., indicated, .pressure ulcer upon admission .how many pressure ulcers .1 (one) .left buttocks .clean with NS, apply triple ATB (antibiotic) ointment, pack with collogen [sic] powder followed by calcium alginate, cover with dry dressing . The document did not indicate description of the pressure ulcer on the left buttocks which includes measurement, appearance, drainage, odor, and appearance of surrounding tissue. A review of Resident C's Wound Consultant Progress Note, dated October 17, 2024, indicated, .Left, Buttock .pressure ulcer stage 3 (three) .measurement 1.0 x 1.0 x 0.4 cm .wound bed .100% granulation .exudate amount (minimal) .skin erythema (mild); macerated (mild) .non selective debridement .full thickness . A review of Resident C's Treatment Nurse New Admission Risk Assessment, dated October 18, 2024, did not indicate description of the left buttocks stage 3 pressure injury. On October 24, 2024, at 9:45 a.m., an interview and concurrent record review was conducted with the TN. The TN stated she did not measure Resident C ' s wound when assessed on October 10, 2024, measurements we not completed until the wound consultant saw the resident on October 17, 2024. The TN stated she did not measure the stage three ulcer to Resident C's left buttocks within the first seven days the resident was at the facility. The TN stated she changed Resident C's dressing to her wound and did not know why there was no documentation on October 10, 2024, October 11, 2024, or October 18, 2024, she was working those days but did not remember. 4. On October 23, 2024, Resident D's record was reviewed. Resident D was admitted on [DATE], with diagnoses which included quadriplegia (partial or total loss of function in all four limbs), and pressure ulcer stage 4 (four) at left buttock. A review of Resident D's care plan, dated September 20, 2024, indicated, .At risk for further skin breakdown . interventions .Monitor skin for signs and symptoms of redness, drainage, fever, foul odor or purulent drainage .Observe for skin improvement or deterioration frequently . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident D's Treatment Nurse New Admission Risk Assessment, dated September 18, 2024, indicated, .Left buttocks St4 (stage 4) . The document did not include description of the wound on the left buttocks. A review of Resident D's wound consultant notes, indicated the following assessment for the stage 4 pressure ulcer on the left buttocks on the following dates: - October 2, 2024, .left buttocks .pressure ulcer stage 4 .5.8 cm x 6.7 cm x 1.2 cm .drainage moderate . slough 20%, granulation tissue 80% .; - October 9, 2024, .5.6 cm x 6.3 cm x 1.4 cm .drainage light .slough 20%, granulation tissue 80% .; - October 16, 2024, .6.5 cm x 6.1 cm x 1.7 cm .drainage light .slough 30% granulation tissue 70% . - October 23, 2024, .6.1 cm x 6.3 cm x 1.3 cm . There was no documented evidence Resident D's stage 4 pressure ulcer at left buttocks was re-evaluated on September 25, 2024. On October 24, 2024, at 11:30 a.m., a concurrent interview and record review was conducted with the TN. The TN stated she did not conduct a comprehensive wound assessment of Resident D's pressure injury on the left buttocks on September 17, 2024 (readmission). The TN stated she did not conduct a wound assessment for Resident D's stage 4 at the left buttocks on the following dates: - September 25, 2024; - October 2, 2024; - October 9, 2024; - October 16, 2024; and - October 24, 2024. The TN stated she would rely on the weekly assessment to be conducted by the wound consultant and should have conducted her own assessment weekly thereafter according to the plan of care. On October 24, 2024, at 2:20 p.m., the Administrator (ADM) was interviewed. The ADM stated the wound consultants were independent consultants and do not work for the facility. The ADM stated the wound consultants would see a resident if the facility request them to. The ADM stte they did not know if the TN was truly assessing the resident's skin condition completely. A review of the facility's policy titled, Change in a Resident's Condition or Status, dated February 2021, indicated, .A 'Significant Change' of condition is a major decline or improvement in the resident's status that: will not normally resolve itself without intervention by staff or by implementing .clinical interventions .requires . revision of the care plan .the nurse will make detailed observations and gather relevant and pertinent information .prompted by the Interact SBAR Communication Form . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy titled, Pressure Injuries Overview, dated March 2020, indicated, .general definitions are derived from the State Operation Manual, Appendix PP: 483.25(b)(1) pressure ulcers (F686) . purposes of staging reference the National Pressure Injury Advisory Panel Classification System .pressure ulcers/injuries occur as a result of intense and/or prolonged pressure or pressure in combination with shear . of soft tissue .may also be affected by skin temperature and moisture, nutrition, perfusion, co-morbidities and condition of soft tissue .'Avoidable' means that the resident developed a pressure ulcer/injury and that one or more of the following was not completed: evaluation of the resident's clinical condition and risk factors . implementation of interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitoring or evaluation of the impact of the interventions .revision of the interventions as appropriate .stage 2 pressure injury: partial thickness skin loss with exposed dermis .granulation tissue, slough and eschar are not present .this stage should not be used to describe moisture-associated skin damage including continence-associated dermatitis, intertriginous dermatitis . A review of the facility's procedure titled Wound Care, dated October 2010, indicated, .provide guidelines for the care of wounds to promote healing .verify that there is a physician's order .review the resident's care plan to assess for any special needs of the resident .dressing material, as indicated .place disposable cloth next to resident (under the wound) to serve as a barrier to protect the bed linen and other body sites .wear sterile gloves when physically touching the wound or holding a moist surface over the wound .the following information should be recorded in the resident's medical record .type of wound care given .date and time wound care was given .position in which the resident was placed .any changes in the resident's condition .all assessment data (i.e., wound bed color, size, drainage, etc.) .how the resident tolerated the procedure . problems or complaints made by the resident related to the procedure . A review of the facility's job description titled Treatment/Quality Assurance Nurse, dated October 2020, indicated, .primary purpose of this position is to assist the Director of Nursing in planning, organizing, developing and directing the day-to-day functions of the using service department in accordance with current federal, state and local standards, guidelines and regulations that govern the facility .ensuring that residents obtain their highest practical physical, mental and psychosocial well-being .meet the current standards of nursing practice, comply with state and federal regulations .perform administrative duties such as completing medical forms, reports, evaluations, studies, charting .participate in regularly scheduled reviews of weights, wounds, clinical updates .participate in Care Plan Committee meetings .make rounds with physicians and wound consultants .treatments are provided as scheduled .provide direct nursing care, including treatments and assessments .perform and teach proper documentation strategies for recording of nursing services . participate in the preliminary and comprehensive assessments of the nursing needs of each resident . participate in the development of a written person-centered treatment and medical care plan for each resident that identifies the problems/needs of the resident, indicates the care to be given, goals to be accomplished and which professional service is responsible for each element of care .make daily rounds of the nursing services department to ensure that all nursing services personnel are performing their work assignments in accordance with acceptable nursing standards .prioritize and schedule tasks to be on a daily/weekly/monthly basis .must be knowledgeable of nursing and medical practices and procedures as well as laws, regulations and guidelines that pertain to nursing care facilities .must possess the ability to plan, organize, develop, implement and interpret the programs, goals, objectives, policies, procedures .for providing quality care .