STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555619	A. Building B. Wing	02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arroyo Grande Care Center	1212 Farroll Ave Arroyo Grande, CA 93420

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47112 Based on interview, and record review, the facility failed to complete an accurate nursing assessment for one of two sampled residents (Resident 1). This failure resulted in the receiving facility not having sufficient information necessary to develop and implement a care plan to meet Resident 1's needs. Findings: During a review of Resident 1's Care Plan (CP) (a document that outlines a patient's health needs and the care they will receive) dated, 1/24/25, the CP indicated, Resident 1 had impaired skin integrity, erythema (skin redness) to sacrococcygeal (the area at the base of the spine) and groin. During an interview on 2/10/25 at 3:05 p.m. with Licensed Nurse (LN 4), LN 4 verbalized they did the assessment, they saw some redness on Resident 1's bottom, got busy and did not document the redness. During a review of Resident 1's Needs upon discharge assessment, dated 1/27/25, the Needs upon discharge assessment indicated, Resident 1's skin was intact. Review of [NAME] and [NAME], Tenth Edition, Fundamentals of Nursing, page 365 in the section titled, Informatics and Documentation, indicated, Documentation is a key communication strategy that produces a written account of pertinent data, clinical decisions and interventions, and patient responses in a health record. Documentation in a patient's health record is a vital aspect of nursing practice.

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