STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555682	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marysville Post-Acute	1617 Ramirez Street Marysville, CA 95901

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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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure discharge planning needs were met for one out of two sampled residents (Resident 1) when: 1. Resident 1 and his wife (CG, caregiver) were not provided required instructions or education on how to properly care for a wound; and 2. Resident 1 was not discharged from the facility with home health services (care provided in the home to include a nurse who would perform wound care, assessments, and education on wound care and dressing changes). This failure had the potential for the wound to worsen and become infected. Findings: 1. A review of the facility's policies and procedures (P&P) titled, Discharging the Resident, dated 9/1/24, indicated, the resident and/or responsible party would receive discharge instructions. A review of the undated document titled, Resident-Based Competencies (demonstrated skills that ensured an individual had the ability to provide adequate care), indicated, when a resident was discharged from the facility, the discharge would be safe and effective (successful). A review of the admission Record, dated 6/1/25, indicated resident 1 was admitted to the facility on [DATE] with the diagnoses of quadriplegia C5-C7, incomplete (messages from the brain to the nerves that made arms and legs move did not always work, which caused a total loss of arm and leg movement at times. C5-C7 was the cervical spinal area in the neck), fusion of the spine cervical region (a surgical procedure that permanently joined two or more moving pieces of the spine together), and bacteremia (bacteria in the blood stream). Resident 1 was his own RP (responsible party, made own decisions). A review of the admission MDS, dated [DATE], indicated 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) was performed. Resident 1 scored 15 out of 15, which indicated intact memory. The admission MDS indicated, Resident 1 required substantial assistance to dress his lower body, rolling in bed from left to right, and both arms and legs were impaired (limited ability to use). (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Admission/readmission Evaluation/Assessment (admission assessment), dated 6/1/25, indicated, Resident 1 did not have any open wounds upon admission to the facility. The admission assessment indicated Resident 1 had discoloration between both buttocks (butt cheeks). The admission assessment indicated, Resident 1 had an old pressure scar (the color and thickness of a pressure scar could indicate the stage of healing after a pressure ulcer was no longer open) and skin discoloration to the right buttock. A review of the Initial Wound Evaluation and Management Summary, dated 6/5/25, indicated, Resident 1 had a wound to the coccyx (also known as the tailbone, located between the buttocks) and the wound doctor performed a surgical debridement (removal of dead tissue) that resulted in dead muscle being removed from the coccyx wound. The Initial Wound Evaluation and Management Summary, indicated, there was a new diagnosis of stage 4 pressure wound of the right coccyx, and a new wound care treatment was required to manage and heal the wound. A review of the Physician's Orders, dated 6/5/25, indicated, a new wound care treatment to Resident 1's coccyx area included: cleaning the wound with normal saline (sterile salty water), pat dry and apply zinc oxide (a medicated cream that promoted wound healing) to the peri-wound (the intact skin that surrounded a wound), apply silver alginate (a medicated dressing) to the wound bed and cover with a foam dressing. During an interview on 6/25/25 at 9:41 am, Resident 1 stated, I did not have any open wounds when I was admitted to the facility. No one taught me or CG how to care for my wound before and I've been to the emergency room three times since I was discharged [from the facility] due to my wound worsening. Resident 1 stated, the emergency room sent me home with wound care supplies and set me up with home health. CG joined the phone call with Resident 1's permission and stated, I was not present during the discharge instructions, we were not given any [wound care] supplies, and I was not given any instruction or education on caring for the wound. CG confirmed that Resident 1 would not be able to perform his own wound care and required CG to perform wound care and dressing changes the coccyx. During a concurrent interview and record review on 6/25/25 at 10:01 am, with Wound Certified Registered Nurse (WCRN) Resident 1's Progress Note, dated 6/6/25 was reviewed. WCRN confirmed, the Progress Note, indicated, Resident 1 was discharged from the facility on 6/6/25, WCRN was the nurse that performed the discharge, and WCRN had provided wound care education. WCRN confirmed Resident 1's wound was located on the coccyx and Resident 1 would not be able to perform his own wound care. WCRN stated, education provided included education on treatments and signs and symptoms of infection. WCRN stated an inability to recall if Resident 1's care giver had been provided with education and instruction on how to perform wound care per the physician's order. WCRN confirmed, the Progress Note, did not indicate who the wound care education was provided to, the supplies needed for wound care, or that a return demonstration (showing someone how to perform wound care and observing them perform the wound care) had been performed with Resident 1's caregiver (CG). During a concurrent interview and record review on 6/25/25 at 10:37 am, with Director of Nursing, (DON) Progress Note, dated 6/6/25 and written by WCRN was reviewed. DON stated, if the patient is alert and oriented [their own responsible party], and able to perform a return demonstration, the wound care education is provided to them. DON confirmed, Resident 1's wound was located on his coccyx and Resident 1 would not be able to perform his own wound care. DON stated, if Resident 1's CG would perform wound care, the CG should have been provided the education. DON confirmed, the Progress Note did not indicate that CG was instructed on wound care or performing dressing changes. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Discharge Summary, dated 6/5/25, indicated, Resident 1 would be discharged home on 6/6/25 and WCRN completed the Nursing Services section. The section labeled Skin Condition Upon Discharge (where the nurse documented any skin concerns, including wounds, and the physician ordered wound care was described) did not include the stage 4 pressure wound of the coccyx and there was no instruction on how to care for it. 2. A review of the facility's P&P titled, Discharging the Resident, dated 9/1/24, indicated, the facility would assist the resident with coordinating care that was required after discharging from the facility such as home health or needed equipment. A review of the Discharge Planning care plan (a document that described resident goals and care required to reach goals), dated 6/6/25, indicated, Resident 1 preferred to be discharged home, would be assessed for discharge needs and would be provided education related to discharge needs. During an interview on 6/20/25 at 3:00 pm, Registered Nurse (RN) confirmed, RN was the nurse who performed Resident 1's admission to the facility on 6/1/25. RN stated, Resident 1 did not want to be in the facility, wanted to go home, and I had to convince him to stay and complete his antibiotic therapy. During an interview on 6/25/25 at 9:41 am, Resident 1 stated, I don't remember anyone offering me home health. No one taught me or CG how to care for my wound and I've been to the emergency room three times since I was discharged [from the facility] due to my wound worsening. Resident 1 stated, the emergency room sent me home with wound care supplies and set me up with home health. Resident 1 confirmed he did not want to be in the facility and RN had convinced him to stay and complete his antibiotic therapy. During a review of Resident 1's Discharge Summary, dated 6/5/25, indicated, the Social Services Director (SSD) completed the section titled, Social Services. The SSD's section indicated that Resident 1 would be discharged home on 6/6/25. The section labeled discharge services and referrals, indicated Resident 1 was not ordered home health services and would need to be seen by his primary care physician within seven days after discharge. During a telephone interview on 6/25/25, at 3:33 pm, SSD stated, There was a case conference note that indicated Resident 1's understanding of leaving the facility unplanned, education was provided, and Resident 1 was notified that he would be required to make a follow up appointment with the doctor after discharge. SSD confirmed, the note would be provided via secured email. SSD confirmed that Resident 1 did not want to be in the facility and wanted to be discharged after the antibiotic therapy was completed on 6/6/25. On 6/27/25 at 7:00 am, Resident 1's provided an IDT Conference Note,, dated 6/5/25 and locked (after a note was written the writer locked it, indicating the note was complete) on 6/19/25, was reviewed. The IDT Conference Note indicated that SSD completed the form, this was an admission conference, and an active discharge plan was being developed for Resident 1 to discharge from the facility the next day (6/6/25). The IDT Conference Note,' indicated, SSD would follow up with any needed appointments and home health. The note indicated, Resident 1 declined home health and understood the risks of leaving unplanned. The IDT Conference Note did not include education provided regarding the dangers associated with declining home health for wound care, that wound care supplies would be needed, or where the wound care supplies could be obtained.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the discharge Minimum Data Set (MDS, a resident assessment tool) was accurate for one out of two sampled residents (Resident 1) when the discharge MDS did not reflect Resident 1's stage 4 (a deep wound that could expose muscle, tendon, or bone) coccyx (also known as the tailbone, located between the buttocks) wound at discharge. This caused an inaccurate reflection of Resident 1's health status and skin condition at discharge and had the potential to impact the discharge planning process. Findings: A review of the Long-Term Care facility Resident Assessment Instrument 3.0 User's Manual (RAI, a manual that provided clear guidance about how to complete the MDS), dated [DATE], indicated, when a resident was discharged from the facility, an assessment was required. The RAI indicated the intent of Section M: Skin Conditions, was to document the presence of wounds. A review of the admission Record, dated 6/1/25, indicated resident 1 was admitted to the facility on [DATE] with the diagnoses of quadriplegia C5-C7, incomplete (messages from the brain to the nerves that made arms and legs work did not always reach the nerves, which caused a total loss of arm and leg movement sometimes. C5-C7 was the spinal area in the neck), fusion of the spine cervical region (a surgical procedure that permanently joined two or more moving pieces of the spine together, cervical region was in the neck area), and bacteremia (bacteria in the blood stream). Resident 1 was his own RP (responsible party, made own decisions). During a concurrent interview and record review on 6/20/25 at 12:30 pm, with MDS Coordinator, Resident 1's admission MDS, Section M: Skin Conditions was reviewed. MDS Coordinator confirmed, the admission MDS indicated, Resident 1 was admitted with two unstageable pressure injuries (a wound that cannot be fully seen) that presented as deep tissue injuries (intact skin that appeared to be discolored due to damage of underlying soft tissue pressure). A review of the Admission/readmission Evaluation/Assessment (admission assessment), dated 6/1/25, indicated, upon the admission assessment, Resident 1 did not have any open wounds. The admission assessment indicated Resident 1 had discoloration between both buttocks (butt cheeks). The admission assessment indicated Resident 1 had an old pressure scar (the color and thickness of a pressure scar indicated the stage of healing after a pressure ulcer was no longer open) and skin discoloration to the right buttock. A review of the Progress Note, dated 6/2/25, indicated, Resident 1 had an open area to the coccyx. A review of the Initial Wound Evaluation and Management Summary, dated 6/5/25, indicated that the wound doctor performed a surgical debridement (removal of dead tissue) of the right coccyx and removed dead tissue and muscle. The Initial Wound Evaluation and Management Summary, indicated a new diagnosis of stage 4 pressure wound of the right coccyx. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/24/25 at 11:35 am, with MDS Coordinator, Resident 1's discharge MDS, dated [DATE], was reviewed. MDS Coordinator confirmed, the discharge MDS, Section M: Skin Conditions, indicated, Resident 1 was discharged with two unstageable pressure injuries that were present upon admission and did not include the physician diagnosed stage 4 pressure ulcer to the coccyx. During an interview on 6/24/25 at 3:04 pm, the MDS Coordinator confirmed the discharge MDS, dated [DATE], should have reflected Resident 1's stage 4 pressure ulcer to the coccyx and it did not.

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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** Based on interview and record review the facility failed to follow their wound prevention, maintenance, and wound care policies and procedures (P&P) for three out of three sampled residents (Residents 1, 2, and 3) when: 1A. Resident 1 was provided wound care without a physician's order; and 1B. Skin assessments did not consistently reflect the condition of the skin or wound, and the discharge skin assessment was not completed; and 1C. A change of condition was not documented; and 2. Residents 1, 2, and 3 were not provided with repositioning every two hours. These failures contributed to Resident 1's wound development and placed residents at an increased risk for a delay in wound healing, decline in health status, and could negatively impact their psychosocial well-being. Findings: 1A. A review of the facility's P&P titled, Wound Care, indicated, a physician's order was required prior to wound care being provided. A review of the admission Record, dated 6/1/25, indicated Resident 1 was admitted to the facility on [DATE] with the diagnoses of quadriplegia C5-C7 incomplete (messages from the brain to the nerves that made arms and legs move did not always work, which caused a total loss of arm and leg movement at times. C5-C7 was the cervical spinal area in the neck), type 2 diabetes mellitus with diabetic neuropathy (inability to control blood sugar that caused nerve damage), muscle weakness, and anemia (decreased amount of red blood cells resulting in a lack of oxygen being carried to the body's tissues.) Resident 1 was his own RP (responsible party, made own decisions). During a concurrent interview and record review on 6/20/25 at 3:00 pm, with Registered Nurse (RN), Resident 1's Nursing Admission/readmission Evaluation/Assessment (admission assessment), dated 6/1/25 was reviewed. RN confirmed performing the admission assessment and stated, the admission assessment indicated, there was no open areas to Resident 1's skin. RN reviewed a progress note, titled Alert Note, dated 6/1/25, and confirmed, the Alert Note, indicated, RN changed dressing (a material that was applied over skin or a wound) on Resident 1's coccyx (also known as the tailbone, located between the buttocks). RN stated, Resident 1 came to the facility with a foam dressing (a padded dressing) on, I applied a new foam dressing for an intervention of safety and skin integrity. There is no order needed. During a concurrent interview and record review on 6/20/25 at 3:27 pm, with Director of Nursing (DON), Resident 1's Physician's orders were reviewed. DON confirmed, a Physician's order was required for nursing to perform dressing changed and confirmed there was no physician order for a dressing change present on 6/1/25. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1B. A review of the facility's (P&P) titled, Prevention of Pressure Injuries, revised 4/1/20, indicated, facility staff would perform skin assessments upon admission, daily, and at discharge. The P&P indicated, Identify any signs of developing pressure injuries (i.e. non-blanchable [discolored skin that did not turn white when pressed] erythema (reddening of the skin]). A review of the P&P titled, Pressure Ulcer Management, revised 7/1/23, indicated, the assessment of a pressure sore included a description of the wound, the stage classification [staging a wound was how the wound was classified, based on the appearance, size, and weather it was an open or closed wound], and appearance of drainage or necrotic [dead] tissue. A review of the Job Description: Treatment Nurse [TN] RN/LPN [Registered Nurse/Licensed Nurse], dated 10/1/16, indicated the TN was responsible for documenting informative and descriptive nursing notes (progress notes), as well as the resident's response to the care. A review of the Job Description: Registered Nurse/RN, dated 2/1/24, indicated the RN was responsible for documenting informative and descriptive nursing notes (progress notes), as well as the resident's response to the care. During a concurrent interview and record review on 6/20/25 at 3:00 pm, with RN, Resident 1's admission assessment, dated 6/1/25 was reviewed. RN confirmed, the section titled, L. Skin Evaluation, indicated, Resident 1 had excoriation (red, raw, or superficial scratches to the skin) near the peri area (skin that surrounded your private parts), discoloration between both buttocks (butt cheeks), and the right buttock had an old pressure scar (thick skin that remained after an open wound had closed) and the skin was discolored. RN confirmed, the section of the admission assessment labeled 1c. Resident has wounds or skin integrity concerns present on admission, was marked as no. RN confirmed, selecting no was inaccurate, and RN should have selected yes due to skin integrity concerns. RN reviewed a progress note titled, Alert Note, dated 6/1/25 and confirmed, the Alert Note, contained additional skin assessment documentation that included Resident 1 arriving to the facility with a coccyx dressing in place and that RN had replaced the old dressing with a new one. RN confirmed, the assessment did not include a description of the coccyx area. During a concurrent interview and record review on 6/25/25 at 10:16 am, with Unit Manager/Licensed Nurse (UN/LN), Resident 1's progress note, titled, Nurses Note, dated 6/2/25 and time stamped at 9:49 am, was reviewed. UM/LN confirmed that the Nurses Note indicated, UN/LN assessed a 3.1 centimeter (cm) in length, opened area to Resident 1's skin, next to the coccyx area on the right buttock that contained slough (dead tissue). UN/LN confirmed the open wound was not staged and stated, if there was a RN here, I would have asked the RN to assess and stage the wound. I don't recall if there was an RN here or not. UM/LN confirmed, when the treatment nurse was not working, UM/LN would perform wound care treatments and stated, I can't stage [wounds], the RN has to. (Resident 1's assigned nurse on 6/2/25 was a RN) A review of the Nursing-Weekly Summary, dated 6/2/25 and time stamped at 10:01 am, indicated, Wound Certified Registered Nurse (WCRN) performed an assessment on Resident 1. The skin assessment section indicated that Resident 1 had excoriation near the peri area, discoloration between both buttocks, and the right buttock had an old pressure scar and the skin was discolored. The documentation was identically written to RN's admission skin assessment. The skin assessment section indicated that there were no new skin issues. The Nursing-Weekly Summary included an area for additional notes. The additional note section indicated that Resident 1 declined having a skin assessment performed. (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 Nursing-Daily Skilled Charting Form, dated 6/2/25 and time stamped 10:12 am, indicated WCRN documented a second skin assessment, indicating Resident 1 had excoriation near the peri area, discoloration between both buttocks, and the right buttock had an old pressure scar and the skin was discolored. The documentation was identically written to RN's admission skin assessment and the Nursing-Weekly Summary (what WCRN had documented at 10:01 am). There was no additional note that indicated Resident 1 had declined a skin assessment. A review of the Nursing-Daily Skilled Charting Form, dated 6/3/25, indicated Resident 1 did not have any wounds, the skin color was normal, and interventions were in place to aid in wound healing. A review of the Nursing-Daily Skilled Charting Form, dated 6/4/25, indicated, Resident 1 did not have any wounds, the skin color was normal, interventions were in place to aide in wound healing, and teaching was provided regarding treatment for a linear (in the shape of a straight line) open area to the coccyx. A review of the Skin & Wound Evaluation, dated 6/4/25, indicated that TN B had performed a wound assessment. TN B documented her wound assessment as an unstageable deep tissue injury (DTI, deep tissue injuries are not open wounds) to the right gluteus (the big muscle inside the butt cheek), and it was present upon admission. The Skin & Wound Evaluation, indicated, Resident 1's wound measured 7.6 cm in length and 4.2 cm in width. The wound bed contained slough. TN B did not indicate on the Skin & Wound Evaluation that Resident 1's wound was on the coccyx or had increased in size. A review of the Initial Wound Evaluation and Management Summary, dated 6/5/25, indicated that the wound doctor performed a surgical debridement (removal of dead tissue) of the right coccyx and removed dead tissue and muscle. The Initial Wound Evaluation and Management Summary, indicated a new diagnosis of stage 4 pressure wound of the right coccyx, full thickness (extended beyond the first two layers of skin and extended into muscle, fat, or bones and was considered a severe wound). The Initial Wound Evaluation and Management Summary, indicated the wound doctor's plan for treatment was to apply a primary dressing (applied directly onto the wound) calcium alginate with silver (a sterile antimicrobial dressing that absorbed drainage) once a day and as needed if the dressing became soiled or damaged. The Initial Wound Evaluation and Management Summary, indicated, the wound doctor's plan for treatment was to apply gauze island dressing (a padded dressing) as a secondary dressing (applied over the primary dressing). A review of the Physician's Orders, dated 6/5/25, indicated, Treatment: unstageable DTI to right gluteus extending to coccyx: Cleanse with normal saline [sterile, salty water], pat dry and apply zinc oxide [medicated cream to promote wound healing] to peri wound [intact skin that surrounded the wound], silver alginate to wound bed and cover with foam dressing. The directions were to change the dressing every day and as needed. A review of the Discharge Summary, dated 6/5/25, signed and dated 6/6/25 by WCRN, indicated, Resident 1 was being discharged home (per Resident 1's request). The section titled, Skin Condition Upon Discharge, indicated Resident 1 had a deep tissue injury to the right gluteus extending to the coccyx and Resident 1 was to monitor for .increase in size, shape, skin breakdown, and/or signs and symptoms of infection until resolved. There was no review or assessment of the stage 4 pressure ulcer to the coccyx or information regarding the treatment plan that the wound doctor initiated. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/25/25, at 10:37 am, with Director of Nursing (DON), admission assessment, dated 6/1/25, progress note, titled, Nurses Note, dated 6/2/25 and time stamped at 9:49 am, Nursing-Weekly Summary, dated 6/2/25 and time stamped at 10:01 am, Nursing-Daily Skilled Charting Form, dated 6/2/25 and time stamped 10:12 am, Nursing-Daily Skilled Charting Form, dated 6/3/25, Nursing-Daily Skilled Charting Form, dated 6/3/25, Skin & Wound Evaluation, dated 6/4/25, Initial Wound Evaluation and Management Summary, dated 6/5/25, and Discharge Summary, dated 6/5/25 was reviewed. DON confirmed wound care assessments and documentation did not consistently reflect the condition of the skin, the location of the wound, or appearance of the wound, and confirmed the discharge skin assessment was not completed. DON confirmed, none of the skin assessments included the stage of the wound and stated, the nurse assessing the wound is responsible for staging it. During the interview, WCRN joined and confirmed being Resident 1's assigned nurse on 6/2/25 and stated, I don't remember if I was notified that Resident 1's wound had changed. WCRN confirmed, both skin assessments that WCRN had documented on 6/2/25 were identically typed when compared to RN's admission skin assessment on 6/1/25, appeared to be copied and pasted, and was not able to recall if WCRN documented or copied and pasted the assessment. WCRN confirmed that there were two separate assessments documented on 6/2/25, one daily and one weekly. WCRN confirmed both documents contained a skin assessment and stated, I didn't assess his skin, he refused. 1C. A review of the facility's P&P titled, Prevention of Pressure Injuries, revised 4/1/25, indicated, facility staff would Evaluate, report, and document potential changes in the skin. A review of Resident 1's admission MDS, dated [DATE], indicated 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) was performed. Resident 1 scored 15 out of 15, which indicated intact memory. The admission MDS indicated Resident 1 required substantial assistance to roll in bed from left to right and both arms and legs were impaired (limited ability to use). During a concurrent interview and record review on 6/20/25 at 3:00 pm, with RN, Resident 1's admission assessment, dated 6/1/25 was reviewed. RN confirmed, the section titled, L. Skin Evaluation (the assessment of the skin), indicated Resident 1 did not have any open wounds upon admission. During a concurrent interview and record review on 6/25/25 at 10:16 am, with UN/LN, Resident 1's admission assessment, dated 6/1/25 was reviewed. UN/LN confirmed, the admission assessment did not indicate Resident 1 had an open wound. Resident 1's progress note, titled, Nurses Note, dated 6/2/25, was reviewed. UM/LN confirmed that the Nurses Note indicated, UN/LN assessed a 3.1 cm in length, opened area to Resident 1's skin, next to the coccyx area on the right buttock that contained slough. UN/LN confirmed, prior to performing a skin assessment, UN/LN should review the previous skin assessment and could not recall if she had. UN/LN stated, it would be considered a change of condition and confirmed, the required change of condition documentation was not completed. During an interview on 6/25/25 at 10:37 am, with DON, Resident 1's admission assessment and progress note, titled, Nurses Note, dated 6/2/25 was reviewed. DON confirmed, the assessments indicated a change of condition and there was no change of condition present in the chart. 2. A review of the facility's P&P titled, Pressure Ulcer Management, revised 7/1/23, indicated, CNAs will attestate [prove, usually through documentation] for their shift that their residents were repositioned at lease every two hours. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555682	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marysville Post-Acute	1617 Ramirez Street Marysville, CA 95901

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/20/25, with Certified Nurse Assistant (CNA) C, Resident 1's task schedule (POC, the area of the electronic medical record where the CNAs documented care provided to residents), dated 6/1/25 through 6/6/25 was reviewed. CNA C confirmed the POC indicated Resident 1 was to be repositioned every shift, not every two hours. CNA C stated, residents are repositioned every two hours and we only chart once a day. Director of Staff Development (DSD) joined the interview and was asked how the CNAs documented that residents were provided with repositioning every two hours. DSD stated, if your resident required repositioning every two hours, then it should be documented every two hours. DSD confirmed, residents with wounds required to be repositioned every two hours and the POC indicated, Resident 1 was repositioned once a shift. A review of the admission Record, dated 4/29/25, indicated that Resident 2 was admitted to the facility on [DATE] with the diagnoses of severe protein-calorie malnutrition (unintended weight loss caused by disease processes or inadequate food consumption), generalized muscle weakness, and difficulty in walking. A review of Resident 2's admission/ 5-day MDS assessment, dated 5/5/25 indicated, a BIMS score of 12 out of 15 (moderately impaired) and required partial/moderate assistance with rolling from side to side in bed. A review of the Wound Evaluation & Management Summary, dated 5/29/25, indicated, Resident 2 had a stage 4 pressure wound of the left coccyx, full thickness. A review of the Physician's Order indicated, facility staff would encourage repositioning every two hours and as needed. A review of the POC, dated 6/1/25 through 6/25/25, indicated CNAs would turn and reposition Resident 1 every shift, not every two hours. A review of admission Record, dated 3/25/25, indicated Resident 3 was admitted to the facility on [DATE] with the diagnosis of muscle weakness and difficulty with walking. A review of Resident 3's admission/ 5-day MDS assessment, indicated that Resident 3 was dependent upon staff to roll from side to side in bed. A review of the Wound Evaluation & Management Summary, dated 4/29/25, indicated Resident 2 had a stage 4 pressure wound of the coccyx, full thickness and required to be repositioned per the facility's protocol. A review of the POC, dated 6/1/25 through 6/25/25, indicated CNAs would turn and reposition Resident 3 every shift, not every two hours. During an interview on 6/25/25 at 9:41 am, Resident 1 stated, they [facility staff] didn't turn me every two hours and confirmed, Resident 1 required assistance with repositioning. During a concurrent interview and record review on 6/25/25 at 2:00 pm, with DON, Resident 2 and 3's POC, dated 6/1/25 through 6/25/25 was reviewed. DON confirmed the POC did not indicate that Residents 2 and 3 were being repositioned every two hours and the POC indicated they were being repositioned every shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555682	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marysville Post-Acute	1617 Ramirez Street Marysville, CA 95901

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/25/25 at 2:29 pm, Resident 3 stated, they don't offer to reposition me, I have to ask, and I only get repositioned, maybe three to four times a day.