STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555706	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Del Amo Gardens Care Center	22419 Kent Avenue Torrance, CA 90505

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	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on interview and record review the facility failed to ensure the resident, who was assessed as a high risk for developing a pressure ulcer (prolonged pressure on the skin that results in injury to the skin and underlying tissue, usually occur over bony prominence because of long-term pressure), did not develop a deep tissue injury ([DTI] (purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure) on the right heel for one of three sampled residents (Resident 1). The facility failed to: 1. Ensure Resident 1 was turned and repositioned every two hours and provided with a pressure reducing device in bed. 2. Ensure staff-maintained offloading (minimizing or removing weight placed on the foot to help prevent and heal pressure ulcers) of Resident 1's right heel away from having a constant pressure against the surface while in bed. These failures resulted in Resident 1 on 4/16/2024 developing DTI measured 6.0 centimeters ([cm] a unit of measurement) in length by 6.0 cm in width on the right heel and on 4/23/2024 measured 6.0 cm in length by 7.0 cm in width. The right heel DTI evolved from a Stage 1 pressure ulcer measured 6.0 cm in length by 6.0 cm in width identified on 4/15/2024. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including hemiplegia (paralysis that affects only one side of the body), hemiparesis (weakness on one entire side of the body), dysphagia (difficulty in swallowing), aphasia (a brain disorder that affects speaking or understanding language), muscle weakness, and abnormalities of gait and mobility. During a review of Resident 1's Nutritional Assessment and Data Collection Form, dated 3/18/2024, the Nutritional Assessment and Data Collection Form indicated Resident 1 was non-ambulatory (not able to walk or exit safely without the physical assistance of another person) and bedfast (a person who is confined to bed) had poor food intake, and was malnourished (when a person's diet does not provide enough nutrients or the right balance for optimal nutrition).The Nutritional Assessment and Data Collection Form indicated Resident 1 had no skin problems. (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

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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	During a review of Resident 1's History and Physical (H&P), dated 3/20/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set ([MDS]- a standardized assessment and care screening tool), dated 4/12/2024, the MDS indicated Resident 1 was dependent on nursing staff for eating, oral hygiene, toileting, showering, upper and lower body dressing, putting on and taking off footwear, personal hygiene, rolling from left to right, sitting, lying, and transferring between surfaces. The MDS indicated Resident 1 required maximum assistance from nursing staff with standing. The MDS indicated Resident 1 was at risk for developing a pressure ulcers/injuries and did not have any pressure ulcers or skin injuries. The MDS section M indicated Resident 1 had a pressure reducing device for bed and was on turning and repositioning program. The MDS section H indicated Resident 1 was always incontinent (no episodes of continent voiding [urination] and bowel movements) of both urine, and bowel. During a review of Resident 1's Braden Scale (an assessment tool to quantify resident risk for developing pressure ulcer represented by a total score and risk categories [low, mild, moderate, high]) for the prediction of pressure ulcer development dated 3/15/2024 indicated Resident 1 had a score of 15 (Severe Risk: Score 9, High Risk: Total score 10-12. Moderate Risk: Total score 13-14 Mild Risk: Total score 15-18.). During a review of Resident 1's care plan titled, At risk for development of pressure injury due to immobility, hemiplegia and hemiparesis, dated 3/18/2024, the care plan indicated the goal for Resident 1 was to be free of avoidable skin breakdown. The care plan interventions included to encourage and assist to offload (no specified information what to offload) as needed, reposition the resident in bed as needed, use a pressure reducing device in bed. During a review if Resident 1's Pressure Ulcer Management Record for the month of 4/2024 indicated Resident 1 had a Stage 1 pressure ulcer to the right heel measured 6.0 cm in length by 6.0 cm in width on 4/15/2024. On 4/16/2024 Resident 1 had the right heel skin injury measured 6.0 cm in length by 6 cm in width and assessed as DTI. On 4/23/2024 Resident 1's right heel skin injury was measured 6.0 cm in length by 7.0 cm in width and assessed as DTI. During an interview on 5/3/2024 at 12:53 p.m., the Licensed Vocational Nurse (LVN 1) stated Resident 1 was admitted to the facility on [DATE] and on 4/4/2024 was admitted to hospice (care provided to a person who is terminally ill and in the last stages of life) due to not eating. LVN 1 stated on 4/15/2024 Resident 1 developed a Stage 1 pressure ulcer with redness to the right heel. LVN 1 stated a physician's order was received on 4/15/2024 to offload both heels for 14 days when Resident 1 in bed. LVN 1 stated Resident 1's Stage 1 pressure ulcer become a DTI on 4/16/2024 with purple discoloration. LVN 1 stated on 4/16/2024 the doctor ordered to cleanse the right heel DTI with Normal Saline (cleansing solution), pat dry, paint with Betadine (an antiseptic used for skin disinfection) solution, cover with dry dressing, and wrap with kerlix (bandage roll). LVN 1 stated Resident 1 was at high risk for developing pressure ulcers due to Resident 1's medical condition, poor food intake, immobility, and incontinence (having no or insufficient voluntary control over urination or defecation) of bowel and bladder. LVN 1 stated Resident 1 developed a pressure ulcer when a pillow, used to offload the resident's right foot away from the mattress, was removed and was left lying directly on the mattress for a long time. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/3/2024 at 1:25 p.m., the Registered Nurse Supervisor (RNS) stated a plan of care for Resident 1, who was at risk for developing a pressure ulcers, should have included the offload of both heels with a pillows, and turning and repositioning of the resident every two hours. RNS stated Resident 1 was at risk for developing a pressure ulcer due to immobility and left sided weakness. RNS stated the cause of Resident 1's pressure ulcer was poor nutrition and constant pressure on the right heel against the mattress. RNS stated there should be a change of condition ([COC] a sudden clinical change from a resident's baseline in physical, cognitive {process of thinking and reason} pressure, behavioral, or functional) completed and Resident 1's reassessment on the Braden Scale to ensure the required interventions to prevent deterioration of the existing pressure sore and improve health process were implemented. RNS stated COC and Braden scale was not done on 4/25/2024 when Resident 1 developed a Stage 1 pressure ulcer on the right heel (4/15/2024) and developed to DTI the next day (4/16/2024). During an interview on 5/6/2024 at 9:40 a.m., LVN 1 stated Resident 1's pressure ulcer to the right heel was avoidable if Resident 1 was being turned, checked, and monitored every 2 hours to ensure both heels were elevated on a pillow to offload the pressure and to prevent DTI. LVN 1 stated Resident 1's Braden scale was not done on 4/15/2024 when there was a change in condition (development of a Stage 1 pressure ulcer to the right heel). During a concurrent interview and record review on 5/7/2024 at 11:46 a.m., with the Director of Nursing (DON), Resident 1's Documentation Survey Report for March 2024 and April 2024, for monitoring the resident's turning and repositioning, were reviewed. The Documentation Survey Report indicated an N (for not turned) was documented on these dates and times: 1. On 3/17/2024 at 4 p.m., 6 p.m., and 8 p.m. 2. On 3/21/2024 at 4 p.m. and 8 p.m. 3. On 3/22/2024 at 4 p.m., 6 p.m., and 10 p.m. 4. On 3/23/2024 at 4 p.m., 6 p.m., and 10 p.m. 5. On 3/24/2024 at 4 p.m., 6 p.m., and 10 p.m. 6. On 3/25/2024 at 4 p.m., 6 p.m., and 10 p.m. 7. On 3/26/2024 at 10 p.m. 8. On 3/29/2024 at 4 p.m., 6 p.m., and 10 p.m. 9. On 3/30/2024 at 12 a.m., 2 a.m., 4 a.m., 6 a.m., 4 p.m., 6 p.m., and 8 p.m. 10. On 3/31/2024 at 12 a.m., 2 a.m., 4 a.m., 6 a.m., 4 p.m., 6 p.m., and 8 p.m. 11. On 4/1/2024 at 12 a.m., 4 p.m., 8 p.m., and 10 p.m. 12. On 4/4/2024 at 10 p.m. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	13. On 4/5/2024 at 4 p.m., 6 p.m. and 8 p.m. 14. On 4/6/2024 at 4 p.m., 6 p.m. and 8 p.m. 15. On 4/7/2024 at 4 p.m., 6 p.m. and 10 p.m. 16. On 4/8/2024 at 4 p.m., 6 p.m. and 8 p.m. 17. On 4/12/2024 at 12 a.m., 2 a.m., 4 a.m., and 6 a.m. 18. On 4/14/2024 at 12 a.m., 2 a.m., 4 a.m., and 6 a.m. 19. On 4/18/2024 at 6 p.m. 20. On 4/24/2024 at 12 a.m. 21. On 4/26/2024 at 8 a.m., 10 a.m., 12 p.m., and 2 p.m. no documentation (blank) 22. On 4/28/2024 at 10 p.m. The Documentation Survey Reports indicated Resident 1 was not turned and repositioned every two hours. The DON stated Resident 1 was at risk for developing pressure ulcers and should have been turned every two hours. The DON stated Resident 1's plan of care for the high risk for developing a pressure ulcer usually includes to turn resident every two hours, hygiene, moisturizing the skin, keeping the skin clean and dry, using pressure reducing devices for the bed and a Registered dietician consultation. The DON stated interventions to prevent a skin break down should be the same regardless of the Braden Scale assessment score. The DON stated repositioning and turning the residents every two hours was a standard nursing practice. The DON stated it was possible for Resident 1 to develop a Stage 1 pressure ulcer and progressed to a DTI with a compromised condition and not implemented preventative measures. The DON confirmed prior to Resident 1 developing a Stage 1 pressure ulcer to the right heel on 4/15/2024, the resident was not turned and repositioned consistently as indicated on the Documentation Survey Reports. According to the nationally recognized Journal of Clinical Nursing, article titled, The Standardized Pressure Injury Prevention Protocol nurses working in health care settings must address pressure ulcer development prevention. The early intervention to prevent pressure injury is required and be integrated into the workflow process. https://onlinelibrary.[NAME].com/doi/full/10.1111/jocn.14691 During a concurrent interview and record review on 5/7/2024 at 11:46 a.m. with the DON, Resident 1's care plan titled, Altered skin integrity due to actual pressure ulcer (right heel) regressed to DTI dated 4/16/2024 was reviewed. The DON confirmed Resident 1's plan of care for DTI did not include interventions for repositioning, turning every two hours and offloading of the right heel. The DON stated it was important to have a resident centered plan of care to prevent progression of a pressure ulcer to DTI. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Treatment Services to Prevent/Heal Pressure Ulcers, revised 3/2023, the P&P indicated, repositioning or relieving constant pressure is a common, effective intervention for an individual with a pressure ulcer/pressure injury or who is at risk of developing one. Assessment of a resident's skin integrity after pressure has been reduced or redistributed should guide the development and implementation of repositioning plans. Such plans should be addressed in the comprehensive care plan consistent with the resident's need and goals. Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning, as the resident is unable to make small movements on their own that would help to relieve prolonged pressure to one area.