STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555712	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morgan Hill Healthcare Center	530 West Dunne Avenue & LA Selva Morgan Hill, CA 95037

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 - 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** 49345 Based on observations, interviews, and record reviews, the facility failed to ensure appropriate and timely treatment and care was provided to one of three sampled Residents (Resident 1) when Resident 1 was only seen by a hand surgeon 33 days from the date of the Physician's order for the referral for possible osteomyelitis (inflammation or swelling that occurs in the bone caused by infection). This failure resulted in Resident 1's left middle finger amputation (surgical removal of a body part) and hospitalization that put Resident 1 at risk for sepsis (a life-threatening complication of an infection). Findings: The clinical records of Resident 1 were reviewed. Resident 1 was originally admitted to the facility on [DATE], readmitted on [DATE] with diagnoses including Other Paralytic Syndrome following unspecified cerebrovascular disease, bilateral (a condition that occurs when a stroke causes loss of muscle movement, or paralysis); chronic obstructive pulmonary disease (COPD, group of lung diseases that block airflow and make it difficult to breathe), diabetes mellitus (too much sugar in the blood), reduced mobility, anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations) and, major depressive disorder (a serious mood disorder that involves a persistent feeling of sadness and loss of interest in activities). Review of Resident 1's Brief Interview for Mental Status (BIMS, (BIMS - an assessment to test a person's cognition level, a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact] dated 9/3/2024, no BIMS score was indicated as this part was not filled out. Review of Resident 1's Interfacility Transfer Report from the acute hospital dated 9/18/2024, indicated, . Nursing Documentation: Behavior: calm cooperative, . Level of Consciousness: alert, Orientation: oriented x 4, Speech: Spontaneous, Mood: Calm During a concurrent observation and interview in Resident 1's room on 11/1/24 at 3:05 p.m. with Resident 1, Resident 1 stated her left-hand hurts when pressed or moved. Resident 1's left-hand had four fingers (thumb, index finger, ring finger, and little finger). A review of Resident 1's progress notes dated 8/1/24 timed 7:30 p.m. by Licensed vocational Nurse (LVN) A indicated, Resident out to appointment accompanied by social services . (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's documents entitled Patient Instructions from the Wound Care Doctor (WCD) dated 8/1/24 indicated, .your left 3rd finger was assessed. You have refused to sign consent for debridement [the process of cleaning a wound and removing any dead tissue]. The document also indicated that WCD recommended Resident 1 to see a hand specialist. The document indicated the name of the Hand Surgeon (HS) and his number. A review of Resident 1's progress notes dated 8/1/24 timed 12:17 p.m. by LVN B indicated, Received orders . for resident to see a hand surgeon .social services aware of referral . A review of Resident 1's X-ray (a photographic or digital image of the internal composition of something, especially a part of the body) of Fingers or Thumb Left dated 8/1/24 indicated, Conclusion: 1. Prominent (obvious) soft tissue (connect, support, and surround the different body organs) swelling tip 3rd finger with large area of ulceration (open sore or wound on the skin) and subjacent (below) bony destruction of the 3rd distal phalanx (the distal or third of the three bones in each finger when counting from the hand to the tip of the finger) from the tuft [tip] of mid shaft [principal part of a long bone] is concerning for underlying soft tissue infection and associated osteomyelitis. A review of Resident 1's progress notes dated 8/9/24 and electronically signed at 9:36 a.m. by Medical Doctor (MD) C indicated, History of Present Illness .Has been seen by wound care who also recommend pt [patient] be seen by hand surgery for further intervention. She completed 6-week course of terbinafine [medication for fungal infections] without any improvement .Plan .pt has completed course of terbinafine without any significant improvement in infection and infection appears to be spreading on hands .Insurance auth [authorization] pending for hand surg [surgeon] consultation . A review of Resident 1's progress notes dated 8/14/24 timed 12:05 p.m. by Social Services Assistant (SSA) indicated, Contacted .hand surgeon's office to schedule appointment for patient. No answer. Left message requesting call back to schedule appointment. No other concerns. A review of Resident 1's progress notes dated 9/3/24 by MD C indicated, Pt has ongoing pain over l. [left] middle finger w [with] some slight bleeding now noted. Pt has appointment w hand surg [surgeon] today .pt states she is amenable to going to the appointment .Plan Hand surg appt [appointment] today .per update from staff later in the day, hand surg recommends pt be taken immediately to ED [emergency department] as she likely has underlying osteomyelitis and may need further amputation of the digit [finger] . A review of Resident 1's progress notes dated 9/3/24 timed 2:57 p.m. by the Director of Nursing (DON) indicated, DON received call from hand surgeon visiting with patient during call while patient is out at the appointment. And surgeon gave verbal recommendations that patient be transferred to ED [emergency department] for further evaluation and treatment for possible finger infection . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's Last General Surgery Note dated 9/3/24 2:00 PM by HS indicated, . Subjective: . female presents with 3-month history of progressive gross (growth?) along the right (typo, meant left) hand that are tender and painful and associated with skin discoloration and ulceration. There is also associated bony destruction of the third distal phalanx which was noted on 8/1/2024 x-ray at her local hospital. She unfortunately did not receive treatment despite the fact there was concern for soft tissue infection and osteomyelitis. As such the infection has progressed. Patient is coming from SNF. She has not undergone MRI to confirm the diagnosis of osteomyelitis. Assessment .In summary, . female with left distal hand infection predominantly involving the long digit but also involving the adjacent digits at the level of the nail. It appears it could be fungal in nature; however, viral and bacterial etiologies are also suspected at this time. Given the finding of potential osteomyelitis on x-ray, there has been a large delay in care since 8/1/2024, that needs to be rectified immediately. I strongly have urged the patient to present to the hospital at this time. She needs infectious disease consultation [IDC, is a conversation between a physician and an infectious disease specialist about a patient or clinical question], MRI [Magnetic Resonance Imaging, a medical imaging technique that uses radio waves to generate detailed pictures of the inside of the body] with conscious sedation [a drug-induced state that helps patients feel relaxed and comfortable during medical or dental procedures while remaining awake and responsive] and consideration for long-term IV antibiotic therapy [a treatment that involves administering antibiotics directly into a vein to fight bacterial infection]. 1. Infection of left hand . Plan: - Recommend patient presents to the emergency room at this time for admission to medicine. - Recommend infectious disease consultation to identify etiology. - Recommend MRI with conscious sedation to rule out osteomyelitis, and if positive, needs 6 weeks of IV antibiotics. A review of Resident 1's progress notes dated 9/3/24 and timed 5:56 p.m. by LVN D indicated, Resident left facility for hospital with ambulance . A review of Resident 1's progress notes dated 9/18/24 and timed 11:22 p.m. by LVN E indicated, Resident arrived [at the facility] at 1930 [7:30 p.m.] .via ambulance . Amputation to left middle finger . A review of Resident 1's Physician Discharge Summary from the hospital with date of service 9/18/2024 indicated, admitted : 9/3/2024 . discharge date : 9/18/2024 .Hospital Problems: . Left 2nd and 3rd distal phalanx [bone at the tip of fingers] infection with osteomyelitis . s/p [status post, a state after an event or procedure] closing wedge osteotomy [a surgical procedure that realigns a bone by removing or opening a wedge of bone]. Left long finger ray amputation [a surgical procedure that removes a finger or toe along with the corresponding bone in the hand or foot] .9/9 [9/9/24] . A review of Resident 1's hospitalization records dated 9/18/24 indicated, XR [x-ray] Hand Left Result date: 9/3/2024 .Impression: Osteomyelitis of the distal phalanx (the third and final bone in each finger, counting from the hand to the fingertip) of the second and third digit [finger] . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview of the Social Services Assistant (SSA) on 11/1/24 at 1:30 p.m., the SSA reviewed Resident 1's progress notes and stated she is responsible for processing residents' referrals to consultant doctors. SSA confirmed she accompanied Resident 1 on her appointment with WCD on 8/1/24 and was aware of WCD's order for referral to a HS. SSA stated she cannot recall the date and time and did not document on Resident 1's chart when she called to schedule an appointment for Resident 1 to see the Hand Surgeon (HS). SSA stated it is a must to document anything done for the resident. SSA stated she should have documented on Resident 1's chart when she received the appointment scheduled for 9/3/24. SSA was not able to present any log or report sheet for social services for tracking finished and pending workload such as residents' referrals to consultant doctors. SSA stated she used a personal notebook to keep track of her work. SSA verified Resident 1's Insurance Authorization Letter for the HS was dated 8/5/24. SSA stated she did not inform Resident 1's primary care doctors that Resident 1 was scheduled to be seen by the HS on 9/3/24. SSA stated she did not ask Resident 1's primary care doctors if there was a need to look for another surgeon with an earlier available schedule. SSA stated she should have informed Resident 1's doctors of the appointment for 9/3/24 to see the HS. During a concurrent interview and record review on 11/1/24 at 2:25 p.m. with the DON, the DON stated he cannot recall the date when he became aware of Resident 1's referral to the HS. The DON stated he knew that SSA was taking care of the referral and did not ask SSA about an update. The DON verified Resident 1's Insurance Authorization Letter for referral to HS was dated 8/5/24. The DON verified on Resident 1's progress notes that there were Interdisciplinary Team Meetings (IDT) done on 8/16/24 for Weight Gain and on 8/29/24 for Open Area to Right Buttock. The DON verified that in both IDTs, the DON was present and Resident 1's pending referral to the HS was not discussed. The DON stated there was a delay for the HS appointment if the referral was made on 8/1/24 and was scheduled on 9/3/24. The DON stated he should have asked SSA what was the cause of the delay. During a telephone interview on 11/5/24 at 12:50 p.m. with the hand surgeon (HS), the HS stated, I can strongly say that the amputation of the finger would have been prevented if she was seen and checked earlier. The HS stated he thought of elderly abuse and negligence when he saw Resident 1's condition. The HS also stated that Resident 1 had MDRO (multidrug-resistant organisms, bacteria that are resistant to more than one antibiotic). The HS stated, I also ran her situation with three other surgeons and all of us were shocked. The HS also stated that the worst that could happen was sepsis (a life-threatening condition that occurs when the body's immune system has an extreme response to an infection or injury) and that could be fatal. During a telephone interview on 11/7/24 at 10:09 a.m. with the WCD, the WCD stated there was nothing acute (urgent) when he saw Resident 1 on 8/1/24 in his clinic. The WCD confirmed he ordered an x-ray of the left hand and a referral to a hand surgeon for Resident 1 on 8/1/24. The WCD stated that there was a delay if it was a month before Resident 1 was seen by the HS after the referral to the HS was ordered. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 11/7/24 at 3:51 p.m. with MD C, MD C stated that she noted external growth on Resident 1's middle finger and it was progressing quite extensively. MD C stated she was never informed that x-ray of the left hand was done for Resident 1 on 8/1/24 and its result. MD C also stated that if she was informed of the result of the x-ray, she would have immediately sent Resident 1 to the emergency department. MD C stated she was not informed when Resident 1's insurance approved the referral to see the HS. MD C also stated that the facility was supposed to inform her when a referral to a consultant doctor was approved by the insurance. MD C stated that on 9/3/24, she visited Resident 1 in the facility, and she was informed of Resident 1's appointment to see the HS on the same day. MD C also stated that if she was informed after the insurance authorized the referral to HS that the appointment was to be on 9/3/24, she would have asked for another surgeon with an earlier available date and she would have ordered a CT scan (a procedure that uses a computer linked to an x-ray machine to make a series of detailed pictures of areas inside the body) of the left hand at least. A review of facility's policy and procedure (P&P) entitled Abuse and Neglect- Clinical Protocol revised July 2017, the P&P indicated, Assessment and Recognition .The nurse will assess the individual and document related findings. Assessment date will include: .j. All active diagnoses; and k. Any recent labs. 2. The nurse will report findings to the physician. As needed, the physician will assess the resident/patient to verify or clarify such findings, especially if the cause or source of the problem is unclear .5. Along with other staff and management, the physician will help identify situations that might constitute or could be construed as neglect . A review of facility's policy and procedure (P&P) entitled Referrals, Social Services Policy dated 7/1/24, the P&P indicated, .3. Social services will collaborate with the nursing staff or other pertinent disciplines to arrange for services that have been ordered by the physician. 4. Social services will document the referral in the resident's medical record .