| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555069 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 08/27/2025 |
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| WESTERN CONVALESCENT HOSPITAL | 2190 W ADAMS BLVD , LOS ANGELES, California, 90018 |

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| F0000 | INITIAL COMMENTS<br><br>The following reflects the findings of the California Department of Public Health during the investigation of two complaints.<br><br>Complaint Numbers: 2596914 and 2600263.<br><br>The inspection was limited to the specific complaint incidents investigated and does not represent the findings of a full inspection of the facility.<br><br>Deficiencies were issued for complaints: 2596914 at F628 and 2600263 at F578, F656, and F686. | F0000 | **Disclaimer:**<br>The signing of this plan of correction is not an admission or agreement of this statement of deficiencies and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. This plan of correction constitutes Facility's written credible allegation of compliance for the deficiencies noted. | |
| F0578<br>SS = D | Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir<br><br>CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)<br><br>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.<br><br>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br><br>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.<br><br>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. | F0578 | **F-578**<br>**Corrective Action**<br><br>On 9/8/25, the Director of Nursing (DON) gave the Social Service Designee(SSD) an inservice about the facility's policy on advanced directive and POLST. Reviewed the process in completing the Advanced Directive and POLST accurately and timely to avoid delay in treatment or life-sustaining procedures in the even of an emergency.<br><br>On On 9/8/25 and 9/11/25, the DON gave the Licensed Nurses an inservice about the facility's policy on advanced directive and POLST. Reviewed the process in completing the Advanced Directive and POLST accurately and timely to avoid delay in treatment or life-sustaining procedures in the even of an emergency. | 9/11/2025 |

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| F0578 SS = D | Continued from page 1<br><br>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.<br><br>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.<br><br>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview and record review, the facility failed to complete the Physician Orders for Life-Sustaining Treatments (POLST – care directive during life threatening situations, an approach to improve end of life care by encouraging providers to speak with patients and create specific medical orders to be honored by healthcare workers during medical crisis) for one of seven sampled residents (Resident 2). This deficient practice placed Resident 2 at risk for delay in treatment or life sustaining procedures during in the event of an emergency.<br><br>Findings:<br><br>During a review of Resident 2's Admission Record, the Admission Record indicated, Resident 2 was initially admitted to the facility on 6/13/2025 with diagnoses including PU Stage 4 (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone), urinary tract infection (UTI – an infection in the bladder/urinary tract), and gastrostomy tube placement (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach for people with swallowing problems).<br><br>During a review of Resident 2's History and Physical (H&P), dated 6/14/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. | F0578 | **Identification of Others**<br>On 9/11/25, the DON and Medical Records Director reviewed all the other charts to review the resident's POLST. No other resident received the deficient practice.<br><br>**Measures to Prevent Recurrence**<br>On 9/8/25, the DON gave the SSD an inservice about the facility's policy on advanced directive and POLST. Reviewed the process in completing the Advanced Directive and POLST accurately and timely to avoid delay in treatment or life-sustaining procedures in the even of an emergency.<br><br>On 9/8/25 and 9/11/25, the DON and/or gave the Licensed Nurses an inservice about the facility's policy on advanced directive and POLST. Reviewed the process in completing the Advanced Directive and POLST accurately and timely to avoid delay in treatment or life-sustaining procedures in the even of an emergency.<br><br>The DON and/or designee will repeat the in services every month for 3 months and then as needed to ensure compliance.<br><br>**Monitoring Performance**<br>Starting 9/11/25, the Medical Records Director and/or designee will review 5 random charts and review if the POLST is complete; weekly x 4 weeks.<br><br>The Administrator, and the DON will present the recapitulations of the findings to the monthly QAPI for review and action as indicated. | |

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| F0578 SS = D | Continued from page 2<br>During a review of Resident 2's Minimum Data Set (MDS – a resident assessment tool), dated 6/19/2025, the MDS indicated Resident 2 had severely impaired cognitive skills (problems with ability to think, use judgement, and reason) for daily decision making. The MDS indicated Resident 2 was totally dependent (helper does all of the effort) on staff with oral hygiene, toileting hygiene, and upper and lower body dressing.<br><br>During a review of Resident 2's Interdisciplinary Team (IDT, team members from different disciplines who come together to discuss resident care) Advance Directives For Care (AD - a written instruction such as a living will or durable power of attorney for health care, recognized under State law, relating to the provision of health care when the individual is incapacitated), the IDT-Advance Directives For Care indicated Resident 2 had a POLST that was elected or in place to reflect resident's healthcare choices.<br><br>During a concurrent interview and record review on 8/27/2025 at 7:23 a.m., with Registered Nurse 1 (RN 1), Resident 2's undated POLST was reviewed. RN 1 stated Resident 2's POLST forms were incomplete. RN 1 stated Resident 2's POLST form under Part A (Cardiopulmonary Resuscitation – an emergency treatment that's done when someone's breathing or heartbeat has stopped), Part B (Medical Interventions), Part C (Artificially Administered Nutrition), and Part D (Information and Signatures) were not checked. RN 1 stated Resident 2's POLST was not signed by the resident's legally recognized decision maker. RN 1 stated Resident 2's POLST was signed solely by the resident's provider. RN 1 stated the provider of Resident 2 should not have signed the POLST since there was missing information on the form. RN 1 stated every section in the POLST should be completely filled out since this was a legal document about the level of care that would be given to Resident 2 in the event of an emergency.<br><br>During an interview on 8/27/2025 at 12:15 p.m., the Director of Nursing (DON) stated it was the responsibility of the Social Worker and the licensed nursing staff to make sure resident's POLST was completely filled out. The DON stated the POLST was a part of resident's AD and should be followed by the health care staff because this was the medical wishes of the resident or her representative when Resident 2's condition deteriorated and became irreversible (permanent). | F0578 | | |

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| F0578 SS = D | Continued from page 3<br><br>During a review of the facility's policy and procedure (P&P) titled, "Quick Reference Guide on POLST in Nursing Homes," dated 5/2024, the P&P indicated, "It should be a standard of practice, before signing the form, for the physician / NP / PA to speak to the resident or, if the resident lacks capacity, the resident's legally recognized decision-maker to confirm that the orders on the POLST are consistent with resident's medical condition and accurately reflect the resident's wishes." | F0578 | | |
| F0628 SS = D | Discharge Process<br><br>CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)<br><br>§483.15(c)(2) Documentation.<br><br>When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.<br><br>(iii) Information provided to the receiving provider must include a minimum of the following:<br><br>(A) Contact information of the practitioner responsible for the care of the resident.<br><br>(B) Resident representative information including contact information<br><br>(C) Advance Directive information<br><br>(D) All special instructions or precautions for ongoing care, as appropriate.<br><br>(E) Comprehensive care plan goals;<br><br>(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.<br><br>§483.15(c)(3) Notice before transfer.<br><br>Before a facility transfers or discharges a resident, the facility must- | F0628 | **F-628**<br>**Corrective Action**<br>On 9/10/25 and 9/11/25, the DON gave the licensed nurses an inservice about the facility's policy on discharge process. Licensed nurses must complete their discharge notes accurately and timely. Discussed that accurate and complete clinical documentation needs to be provided during resident's discharges to provide better interfacility communication and continuity of care.<br><br>On 9/9/25, the Director of Nursing (DON) gave the transferring RN for Resident1 an inservice about the facility's policy on discharge process. Discussed that accurate and complete clinical documentation needs to be provided during resident's discharges to provide better interfacility communication and continuity of care.<br><br>**Identification of Others**<br>On 9/11/25, the DON and Clinical Manager assessed other discharge charts. No other resident received the deficient practice.<br><br>**Measures to Prevent Recurrence**<br>On 9/10/25 and 9/11/25, the DON gave the licensed nurses an inservice about the facility's policy on discharge process. Licensed nurses must complete their discharge notes accurately and timely. Discussed that accurate and complete clinical documentation needs to be provided during resident's discharges to provide better interfacility communication and continuity of care. | |

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| F0628 SS = D | Continued from page 4<br><br>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.<br><br>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and<br><br>(iii) Include in the notice the items described in paragraph (c)(5) of this section.<br><br>§483.15(c)(4) Timing of the notice.<br><br>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.<br><br>(ii) Notice must be made as soon as practicable before transfer or discharge when-<br><br>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;<br><br>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;<br><br>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;<br><br>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or<br><br>(E) A resident has not resided in the facility for 30 days.<br><br>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:<br><br>(i) The reason for transfer or discharge; | F0628 | The DON and/or designee will repeat the in services every month for 3 months and then as needed to ensure compliance.<br><br>**Monitoring Performance**<br>Starting 9/11/25, the Medical Records Director and/or designee will review 5 random discharge charts and review if the discharge documentation is complete; weekly x 4 weeks.<br><br>The Administrator, and the DON will present the recapitulations of the findings to the monthly QAPI for review and action as indicated. | |

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| F0628 SS = D | Continued from page 5<br>(ii) The effective date of transfer or discharge;<br><br>(iii) The location to which the resident is transferred or discharged;<br><br>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;<br><br>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;<br><br>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and<br><br>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.<br><br>§483.15(c)(6) Changes to the notice.<br><br>If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.<br><br>§483.15(c)(8) Notice in advance of facility closure<br><br>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). | F0628 | | |

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| F0628 SS = D | Continued from page 6<br><br>§483.15(d) Notice of bed-hold policy and return-<br><br>§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-<br><br>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;<br><br>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;<br><br>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1 ) of this section, permitting a resident to return; and<br><br>(iv) The information specified in paragraph (e)(1) of this section.<br><br>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.<br><br>§483.21(c)(2) Discharge Summary<br><br>When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:<br><br>(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.<br><br>(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.<br><br>(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). | F0628 | | |

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| F0628 SS = D | Continued from page 7<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 1's) transfer to the general acute care hospital (GACH) was documented in resident's medical records. This deficient practice had the potential to place Resident 1 at risk of not receiving appropriate care and delay in communication among staff due to incomplete medical records.<br><br>Findings:<br><br>During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was initially admitted to the facility on 3/21/2025 and readmitted on 8/5/2025 with diagnoses including chronic respiratory failure with hypoxia (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), tracheostomy (an opening created at the front of the neck so a tube can be inserted into the windpipe [trachea] to help you breathe), and gastrostomy tube placement (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach for people with swallowing problems).<br><br>During a review of Resident 1's History and Physical (H&P), the H&P indicated Resident 1 did not have the capacity to understand and make decisions.<br><br>During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 7/3/2025, the MDS indicated Resident 1 had severely impaired cognitive skills (problems with ability to think, use judgement and reason) skills for daily decision making. The MDS indicated Resident 1 was totally dependent (helper does all of the effort) on staff with oral hygiene, toileting hygiene, and upper and lower body dressing.<br><br>During a review of the Physician's Order Summary Report dated 8/16/2025, the Order Summary Report indicated the physician placed a telephone order on 8/15/2025 for Resident 1 to be transferred to the GACH.<br><br>During a concurrent interview and record review on 8/26/2025 at 12:37 p.m. with the Clinical Manager (CM), Resident 1's medical records were reviewed. The CM | F0628 | | |

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| F0628 SS = D | Continued from page 8<br>stated Resident 1's medical records were incomplete and not accurate. The CM stated there was no documentation by facility staff indicating Resident 1 was transferred to the GACH on 8/15 or 8/16/2025. The CM stated the licensed nurse should have documented Resident 1's clinical condition, vital signs (basic measurements of your body's core functions, including temperature, pulse rate, respiratory rate (breathing), and blood pressure) and other pertinent information at the time of transfer. The CM stated accurate and complete clinical documentation provided better evaluation of the resident for continuity of care.<br><br>During a review of the facility's undated policy and procedure (P&P) titled, "Medical Records," the P&P indicated the facility shall maintain complete, accurate, readily accessible and systematically organized medical records for each resident admitted to the facility.<br><br>During a review of the facility's undated P&P titled, "Charting and Documentation," the P&P indicated, "All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record." | F0628 | | |
| F0656 SS = D | Develop/Implement Comprehensive Care Plan<br><br>CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br><br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br><br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br><br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, | F0656 | **F -656**<br>**Corrective Action**<br>On 9/10/25 and 9/11/25, the DON gave the licensed nurse an inservice on how to develop and implement a comprehensive care plan for wounds. The comprehensive care plan serves as a guide in providing appropriate wound care interventions to promote healing; and avoid infection and/or worsening.<br><br>On 9/10/25 and 9/11/25, the MDS Consultant gave the MDS nurses an inservice about the facility's policy on developing a comprehensive care plan. Wound care plans should be integrated in the comprehensive care plans. | |

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| F0656 SS = D | Continued from page 9<br>including the right to refuse treatment under §483.10(c)(6).<br><br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br><br>(iv)In consultation with the resident and the resident's representative(s)-<br><br>(A) The resident's goals for admission and desired outcomes.<br><br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br><br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br><br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(iii) Be culturally-competent and trauma-informed.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview and record review, the facility failed to ensure a comprehensive care plan for pressure ulcer/injury (PU/PI] - localized damage to the skin and/or underlying tissue usually over a bony prominence) was developed for one of four sampled residents (Resident 2), who had multiple pressure ulcers. This deficient practice had the potential for Resident 2 not receiving the appropriate wound care interventions which could lead to infection or worsening of the wounds.<br><br>Findings:<br><br>During a review of Resident 2's Admission Record, the Admission Record indicated, Resident 2 was initially admitted to the facility on 6/13/2025 with diagnoses including PU Stage 4 (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone), urinary tract infection (UTI – an infection | F0656 | **Identification of Others**<br>On 9/11/25, the DON and Medical Records Director reviewed other residents wound care plans. No other resident received the deficient practice.<br><br>**Measures to Prevent Recurrence**<br>On 9/10/25 and 9/11/25, the DON gave the licensed nurse an inservice on how to develop and implement a comprehensive care plan for wounds. The comprehensive care plan serves as a guide in providing appropriate wound care interventions to promote healing; and avoid infection and/or worsening.<br><br>On 9/10/25 and 9/11/25, the MDS Consultant gave the MDS nurses an inservice about the facility's policy on developing a comprehensive care plan. Wound care plans should be integrated in the comprehensive care plans.<br><br>The DON and/or designee will repeat the in services every month for 3 months and then as needed to ensure compliance.<br><br>**Monitoring Performance**<br>Starting 9/11/25, the Medical Records Director and/or designee will review 5 random charts of resident with wounds and review if they have comprehensive care plans for wounds; weekly x 4 weeks.<br><br>The Administrator, and the DON will present the recapitulations of the findings to the monthly QAPI for review and action as indicated. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555069 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 08/27/2025 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| WESTERN CONVALESCENT HOSPITAL | 2190 W ADAMS BLVD , LOS ANGELES, California, 90018 |

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| F0656 SS = D | Continued from page 10<br>in the bladder/urinary tract), and gastrostomy tube placement (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach for people with swallowing problems).<br><br>During a review of Resident 2's History and Physical (H&P), dated 6/14/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions.<br><br>During a review of Resident 2's Minimum Data Set (MDS – a resident assessment tool), dated 6/19/2025, the MDS indicated Resident 2 had severely impaired cognitive skills (problems with ability to think, use judgement, and reason) for daily decision making. The MDS indicated Resident 2 was totally dependent (helper does all of the effort) on staff with oral hygiene, toileting hygiene, and upper and lower body dressing. The MDS indicated Resident 2 was at risk for developing a pressure ulcer and had three stage 4 pressure ulcers and two unstageable pressure ulcers (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough (dead tissue that is usually yellow, tan, gray, or green in color, usually moist and stringy in texture, that may be found in wounds) or eschar (dead tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like, usually firmly attached to the base, sides and/or edges of the wound and over time falls off) that were present upon admission.<br><br>During a concurrent interview and record review on 8/27/2025 at 2:30 p.m., with the Clinical Manager (CM), Resident 2's care plans were reviewed. The CM stated the facility developed a baseline care plan for Resident 2 upon admission, but no comprehensive care plan was developed (over two months later). The CM stated Resident 2 had no comprehensive care plan addressing her multiple PU's which was important because it served as a guide for monitoring and treatment of pressure ulcers. The CM stated without a comprehensive care plan, there would be no specific guidance for Resident 2's wound care.<br><br>During an interview on 8/27/2025 at 3 p.m., the Director of Nursing (DON) stated the baseline care plan was good for 14 days. The DON stated the comprehensive care plan should be developed by the interdisciplinary team (IDT, members from different disciplines who come | F0656 | | |

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| F0656 SS = D | Continued from page 11<br>together to discuss resident care) 14 days after admission, quarterly and as needed. The DON stated it was important to develop a comprehensive care plan for PU for Resident 2 to evaluate the effectiveness of wound care treatment and to provide other interventions.<br><br>During a review of the facility's undated policy and procedure (P&P) titled, "Guide to Comprehensive Care Plans," the P&P indicated to ensure a comprehensive care plan was created for skin alterations, pressure ulcers, vascular ulcers, and diabetic ulcers. The P&P also indicated to ensure that care plan goals were realistic, measurable, and included a time frame for re-evaluation. | F0656 | | |
| F0686 SS = D | Treatment/Svcs to Prevent/Heal Pressure Ulcer<br><br>CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br><br>§483.25(b)(1) Pressure ulcers.<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br><br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br><br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 2), who had multiple pressure ulcers / injury (PU/PI - localized damage to the skin and/or underlying tissue usually over a bony prominence) received care in accordance with professional standards of practice. Resident 2's PU's were not reassessed weekly including the type of the PU, location, measurement and description. This deficient practice caused an increased risk in the worsening of Resident 2's pressure ulcers and inappropriate or delayed treatment.<br><br>Findings: | F0686 | **F -686**<br>**Corrective Action**<br>On 9/10/25, the DON gave the Treatment nurses an inservice about the facility's policy on reassessing wound weekly. Wound sites will be reassessed weekly and documented timely.<br><br>On 9/10/25, the DON gave the licensed nurse an inservice about the facility's policy on reassessing wound weekly. Wound sites will be reassessed weekly and documented timely.<br><br>**Identification of Others**<br>On 9/11/25, the DON and Treatment nurse reviewed other residents weekly wound assessment and documentation. No other resident received the deficient practice.<br><br>**Measures to Prevent Recurrence**<br>On 9/10/25, the DON gave the Treatment nurses an inservice about the facility's policy on reassessing wound weekly. Wound sites will be reassessed weekly and documented timely.<br><br>On 9/10/25, the DON gave the licensed nurse an inservice about the facility's policy on reassessing wound weekly. Wound sites will be reassessed weekly and documented timely. | |

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| F0686 SS = D | Continued from page 12<br><br>During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on 6/13/2025 with diagnoses including PU Stage 4 (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone), urinary tract infection (UTI – an infection in the bladder/urinary tract), and gastrostomy tube placement (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach for people with swallowing problems).<br><br>During a review of Resident 2's Baseline Care Plan dated 6/13/2025, the care plan indicated Resident 2 had Impaired Skin Integrity manifested by pressure ulcer sites on the sacrum, right knee (DTI), right foot, right and left toes. The care plan interventions indicated to provide treatment as ordered and monitor for signs and symptoms of infection.<br><br>During a review of Resident 2's History and Physical (H&P), dated 6/14/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions.<br><br>During a review of Resident 2's Minimum Data Set (MDS – a resident assessment tool), dated 6/19/2025, the MDS indicated Resident 2 had severely impaired cognitive skills (problems with ability to think, use judgement, and reason) for daily decision making. The MDS indicated Resident 2 was totally dependent (helper does all of the effort) on staff with oral hygiene, toileting hygiene, and upper and lower body dressing. The MDS indicated Resident 2 had three Stage 4 pressure ulcers and two unstageable pressure ulcers (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough [dead tissue that is usually yellow, tan, gray, or green, usually moist and stringy in texture, that may be found in the wounds] or eschar [dead tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like, usually firmly attached to the base, sides and/or edges of the wounds]) that were present upon admission. The MDS also indicated Resident 2 was at risk for developing a pressure ulcer.<br><br>During a concurrent interview and record review on | F0686 | The DON and/or designee will repeat the in services every month for 3 months and then as needed to ensure compliance.<br><br>**Monitoring Performance**<br>Starting 9/11/25, the DON and/or designee will review 5 random charts of resident with wounds and review if they have wompleted their weekly wound assessment; weekly x 4 weeks.<br><br>The Administrator, and the DON will present the recapitulations of the findings to the monthly QAPI for review and action as indicated. | |

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| F0686 SS = D | Continued from page 13<br>8/27/2025 at 11:45 a.m., with Treatment Nurse 1 (TN 1), Resident 2's weekly wound report dated 8/14/2025 was reviewed. TN 1 stated he was not able to reassess and document Resident 2's PU's on 8/21/2025 (one week later). TN 1 stated Resident 2's PU's should be reassessed and documented weekly in the skin and wound evaluation report. TN 1 stated weekly PU reassessment should include the type of the PU, location, measurement and the description, to determine the status and progression of the PU and to make necessary adjustments on wound care treatment plan.<br><br>During a review of the facility's Treatment Nurse Job Description, the Treatment Nurse Job Description indicated to maintain a pressure ulcer profile for every pressure ulcer, update weekly and as needed to reflect accurate measurement and progress, and ensured resident received appropriate prophylaxis and treatment. The Job Description did not indicate the Treatment Nurse would review and revise the resident's pressure ulcer care plan as needed for accurate and specific guidance of wound care and evaluate the effectiveness of the treatment.<br><br>During a review of the facility's policy and procedure (P&P) titled, "Pressure Ulcers / Skin Breakdown Clinical Protocol," dated 4/2018, the P&P indicated "The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers." The P&P did not indicate to reassess the pressure ulcer weekly on a scheduled basis to determine the progression of the pressure ulcer. | F0686 | | |