STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555716	A. BUILDING _____ B. WING _____	**07/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARKWEST HEALTHCARE CENTER	**6740 WILBUR AVE RESEDA, CA 91335**

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** - Minimal harm or potential for 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** Based on interview and record review, the facility failed develop a baseline plan of care for one of three sampled residents (Resident 1). For Resident 1, who was readmitted with a pressure sores (injury to skin and underlying tissue resulting from prolonged pressure on the skin), a baseline care plan was not develop to address Resident 1's pressure sore for the nursing staff to implement measures to promote healing of the pressure sore. This deficient practice placed Resident 1 at risk of complications from pressure sores and delayed healing. Findings: A review of Resident 1's Admission Record indicated a readmitted d 3/31/2020, with [DIAGNOSES REDACTED].), and dependence on ventilator (a machine that assist the person with breathing). A review of Resident 1's Minimum Data Set (MDS - standardized assessment and care-screening tool) dated 3/21/2020, indicated Resident 1's was unable to make decisions and was totally dependent on staff with bed mobility, transfer, dressing, eating, toilet use, and personal hygiene. During an interview and concurrent record review with Treatment Nurse (TN), on 7/2/2020, at 1:57 p.m., TN stated when a resident is admitted /readmitted after hours or when the treatment nurse is no longer in the facility the admitting Registered Nurse (RN) will conduct an initial skin assessment. The following day, when the treatment nurse is on duty, the treatment nurse will reassess the admitted /readmitted resident for any additional skin findings. TN stated Resident 1 was readmitted with one Stage II (the skin breaks open, wears away, or forms an ulcer, which is usually tender and painful) pressure injury on the sacral coccyx area (tailbone area). TN was unable to find the skin reassessment the day following Resident 1's readmission. The TN was unable to find a baseline care plan addressing Resident 1's pressure sore, During an interview and concurrent record review with Registered Nurse Supervisor 1 (RN 1), on 7/6/2020, at 2:20 p.m., RN 1 reviewed the clinical record, confirmed RN 1 stated the treatment nurse should have done a reassessment of Resident 1's pressure injury the next day, after readmission. RN 1 further stated the treatment nurse should have done a reassessment to double check if the previous skin assessment was done accurately and if there were any changes since admission. RN 1 was unable to find a baseline care plan for Resident 1's pressure sore developed on admission. A review of the facility's policy and procedures titled Care Plans-Preliminary, dated revised August 2016 indicates a preliminary plan of care to meet the resident's immediate needs shall be developed for each resident with twenty-four (24) hours of admission. The interdisciplinary Team will review the attending physician's orders [REDACTED]. The policy further to indicate the preliminary care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary care plan.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain complete and accurate medical records in accordance with the facility's policy for one of three sampled residents (Resident 1). Resident 1's readmission assessment was incomplete. This deficient practice placed the resident at risk of not receiving appropriate care. Findings: [DIAGNOSES REDACTED].), and dependence on ventilator (a machine that assist the person with breathing). A review of Resident 1's Minimum Data Set (MDS - standardized assessment and care-screening tool) dated 3/21/2020, indicated Resident 1's was unable to make decisions and was totally dependent on staff with bed mobility, transfer, dressing, eating, toilet use, and personal hygiene. During an interview and concurrent record review with Treatment Nurse (TN), on 7/2/2020, at 1:57 p.m., TN stated when a resident is admitted /readmitted after hours or when the treatment nurse is no longer in the facility the admitting Registered Nurse (RN) will conduct an initial skin assessment. The following day, when the treatment nurse is on duty, the treatment nurse will reassess the admitted /readmitted resident for any additional skin findings. TN stated Resident 1 was readmitted with one Stage II (the skin breaks open, wears away, or forms an ulcer, which is usually tender and painful) pressure injury on the sacral coccyx area (tailbone area). TN was unable to find the skin reassessment the day following Resident 1's readmission. The TN was unable to find a baseline care plan addressing Resident 1's pressure sore, On on 7/6/2020, at 2:10 p.m., during an interview with Registered Nurse Supervisor 1 (RN 1), and concurrent review of the form Nursing History and Admission Assessment RN 1 completed, RN 1 stated the documentation was incomplete, it did not include (left blank) the time, height, weight, age, and bowel and bladder status. RN 1 did not sign three of four pages of the form. A review of the facility's policy and procedures titled Resident Examination and Assessment, dated revised February 2014, indicates the following information should be recorded in the resident's medical record: 1. The date and time the procedure was performed. 2. The name and title of the individual(s) who performed the procedure. 3. All assessment data obtained during the procedure. 4. How the resident tolerated the procedure. 5. If the resident refused the procedure, the reason(s) why and the intervention taken. 6. The signature and title of the person recording the data.

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