STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055412	A. BUILDING _____ B. WING _____	**03/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ORCHARD POST ACUTE CARE	**101 S ORCHARD AVE VACAVILLE, CA 95688**

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 -** Minimal harm or potential for 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** Based on observation, interview and record review, the facility failed to follow nursing care plan precautions to prevent a pressure sore from developing from a Stage I (redness on skin without breakdown) to a Stage 3 (full thickness tissue loss), for one of four sampled residents, (Resident 1). This failure resulted in Resident 1's pressure injury progressing from a Stage I blister to a Stage 3 pressure ulcer, putting the Resident at risk for an enlarged wound, and infection. Findings: Review of a California Department Health complaint, dated 10/24/19, indicated care concerns including: 1. On 12/30/18, Resident 1's family member 1 visited Resident 1 at the facility and identified Resident 1's pressure ulcer was worse; and, 2. On 12/31/18, Resident 1's family visited Resident 1 and noted the facility had no pressure ulcer interventions in place. Resident 1 was discharged to the hospital on [DATE], 12/26/18 and 12/31/18. An interview with the Complainant on, 11/5/19, at 1:44 p.m., indicated Resident 1's family would have to be interviewed for additional details. On 11/7/19 at 9:28 a.m., review of the daily census indicated Resident 1 was no longer a resident of the facility. An interview with the Minimum Data Set (MDS) Coordinator on 12/4/19 at 11:20 a.m., she stated he (Resident 1) did not have a pressure ulcer on admission on 11/10/2018. Resident 1 was transferred to the hospital on [DATE], and returned on 12/11/18, with no pressure sore. On 1/3/19, he was discharged home with a pressure sore. During an interview with the Director of Nursing (DON) on 12/4/19 at 11:30 a.m., he stated Resident returned from a family visit on 12/25/18, at approximately 9 p.m., and on 12/26/18, he went to the hospital shortly after midnight, and when he returned to the facility at 4:36 p.m., there was a blister. A review of Resident 1's Admission-Resident Data Collection, dated 11/10/18 at 9:11 p.m., signed by Licensed Nurse F, indicated: C. Skin Integrity, Site 23) coccyx - blanchable redness. Resident 1's nursing care plans, for, Impaired Skin Integrity, initiated 12/14/18, indicated Resident 1 required assistance with turning and repositioning. The goal for skin care indicated Resident 1's skin should remain intact and free of redness, blisters or discoloration. Interventions to maintain skin integrity and prevent sores or pressure ulcers included applying lotion after bathing, encouraged fluid intake and repositioning, weekly skin evaluation, monitoring incontinence, and notifying Resident 1's physician immediately of any signs of breakdown, pressure reducing cushion to Resident 1's wheelchair (which was not done, according to Resident 1's family member) and skin checks during care at every shift. Review of Resident 1's nursing report, 12/26/18 at 1:04 a.m., indicated Licensed Nurse E documented she had flushed Resident 1's Foley catheter, which had dark urine, during which Resident 1 reported pain in his lower left abdomen, and grimaced in pain when Licensed Nurse E flushed Resident 1's Foley. The document did not indicate Resident 1 had signs of a pressure ulcer. Licensed Nurse E documented the facility transferred Resident 1 to the Emergency Department (ED) at 12:35 a.m., and he returned to the facility on [DATE], at 4:36 p.m. Review of the facility's form for change of condition, Situation Background Assessment Recommendation (SBAR), 12/26/18, at 4:36 p.m., indicated Resident 1's family returned Resident 1 from ED (16 hours after the facility had transferred Resident 1 out), and told the facility Resident 1 had a Stage I pressure ulcer on his left hip. In addition, the family reported Resident 1 had a rash and scattered redness on his peri area and buttocks. During a review of city of Vacaville's Fire Department Patient Care Record, dated 12/31/18, indicated Resident 1's family called 911 to transport Resident 1 to an Emergency Department (ED) for a visible redness on Resident 1's left hip, which appeared open with white pus. During a review of notes from Resident 1's ED visit, on 12/31/18, Physician 3's note, dated 12/31/18 at 7:28 p.m., indicated: Physical exam: Extremities: Right BKA, left hip 2 cm stage II pressure ulcer with some mild [DIAGNOSES REDACTED] surrounding it. Medical Decision Making: developing left pressure ulcer from rubbing on a wheelchair, not apparently terribly infected. I do not suspect surrounding [MEDICAL CONDITION] although there is likely a mild infection developing in the ulcer. I will have the nurse provide wound care and [MEDICATION NAME] topically. During a review of the Resident's Care plan, dated 1/1/19, indicated Resident 1 had a Pressure injury to his left trochanter (the trochanter is located at the proximal (near) and lateral (outside part of the shaft of the femur (the large leg bone) indicating a Stage 3 level. Resident 1's MDS confirmed the pressure ulcer, under, Section M, dated 1/2/19, which indicated he had a Stage 3 Pressure ulcer. A review of Physician 3's Progress Note, dated 1/2/19, indicated Resident 1 presented to the ED with a chief complaint of a pressure sore on the left hip, sustained from rubbing it on a wheelchair at his nursing facility. The Progress Note documented Resident 1's family brought him to the ED because the pressure ulcer had been developing and getting more swollen and redder over the last several days, and the family did not feel the facility had done anything to prevent it. Resident 1's family had asked for a new wheelchair, which had not been provided, because Resident 1's leg rubbed on a screw head as he pulled himself along using his left leg. The document indicated Resident 1's family had provided photos showing some progression of the ulcer. An interview with Resident 1's family member on 3/16/19, at 4:48 p.m., stated the family decided to discharge Resident 1 to another facility, as they saw Resident 1's pressure ulcer had enlarged and become worse. Resident 1's family member stated the facility had not provided a wheelchair pad, per family request (or per care plan, dated 12/14/18). Review of the facility's policy and procedure titled, Pressure Ulcer Treatment, dated 2001 (Revised December 2007), indicated: Purpose: The purpose of this procedure is to provide guidelines for the care of existing pressure ulcers and the prevention of additional pressure ulcers. Preparation 1. Review the resident's care plan to assess for any special needs of the resident Stage 1 Protocol: 1. Pressure a. Determine cause of pressure and relieve; b. Redistribute pressure; c. Implement pressure-relieving device(s) in accordance with resident's assessed needs; d. Evaluate until redness is no longer persistent; e. Persistent redness is determined only after pressure has been relieved for at least of the time it was applied and the redness remains; f. Notify Physician, family and appropriate facility personnel; and, g. Initiate a skin grid and care plan. 2. Incontinence a. Cleanse with incontinence cleanser; b. Pat dry an evaluate need for protective barrier cream; and, c. Consider scheduled toileting program 3. Friction or Shearing a. Reduce cause by using transfer techniques and devices as needed 4. Immobility a. Turn schedule b. Restorative Nursing (range of motion, walking, bed mobility) Follow-up If wound does not improve in 2-3 weeks, notify Physician. Consider a skin consult with wound specialist.

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

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.