STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555808	A. BUILDING _____ B. WING _____	**09/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE REHABILITATION CENTER OF SANTA MONICA	**1338 20TH STREET SANTA MONICA, CA 90404**

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for one of two sampled residents (Resident 1's) regarding cutting of toe nails. This deficient practice had the potential for Resident 1 to not receive care and services regarding cutting of toe nails. Findings: A review of the Resident Face Sheet (Admission Record) indicated the facility originally admitted Resident 1 on 11/16/2007 and re-admitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 1's Podiatrist (a doctor who has been trained to diagnose and treat abnormal conditions of the feet and lower limbs) Physician's Notes, dated 9/20/2018, indicated Resident 1 had a history of [REDACTED]. The document indicated all toenails were debrided (removed damaged tissue) of any devitalized (dead) nail tissue, noting the nails appeared gryphotic (such as nail having a curvature) and symptomatic. These notes were the last documentation of care of the nails. Resident 1 visited the podiatrist on 11/27/2018, 12/27/2018, and 1/31/2019 but had refused care on those visits, according to Resident 1's Podiatrist Notes. A review of Resident 1's Interdisciplinary (IDT, a team of disciplines such as social services, nursing, nutrition, etc. who meet to plan care for a resident) Notes, dated 4/28/2020 and 6/15/2020 did not indicate any documentation regarding toe nails being trimmed. A review of Resident 1's General Acute Care Hospital (GACH) Social Worker's (GSW) Notes, dated 8/24/2020, indicated the Family Member 1 (FM 1) showed the GSW how long Resident 1's toe nails were. A review of Resident 1's Minimum Data Set (MDS - an assessment and care screening tool), dated 8/31/2020, indicated Resident 1 was moderately impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) in daily decision making skills. Resident 1 required one-person extensive assistance with dressing, and personal hygiene and two-person assistance with transfer from bed to wheelchair. During an interview with the Director of Nursing (DON) on 9/11/2020 at 11:55 AM, she stated she was unsure when Resident 1 was last seen by a podiatrist. During a phone interview with the DON on 9/15/2020 at 9:45 AM, she stated that the licensed charge nurses cut a resident's nails but did not document since it was not a change in condition. The DON stated Resident 1 had aggressive behavior and kicks, and we had to go back when she was in a better mood. The DON stated there was no care plan regarding the cutting of Resident 1's toe nails, but will be developing one for the future. The DON was unable to provide any record of when Resident 1's toe nails were last cut or by which licensed staff. A review of the policy and procedure titled, Foot Care, reviewed on 1/31/2019, indicated that for In the care plan, document the need for foot care.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 ensure that one of two sampled residents (Resident 1) received treatment and care based on a comprehensive assessment in accordance with resident's preferences, goals for care and professional standards of practice by not addressing the following issues: 1. Left posterior (back portion) ear fungal infection upon readmission from the hospital; and 2. Foot Care. These deficient practices had the potential for Resident 1 to have untreated fungal infection behind the ear and not receive any footcare. Findings: A review of the Resident Face Sheet (Admission Record) indicated the facility originally admitted Resident 1 on 11/16/2007 and re-admitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS - an assessment and care screening tool), dated 8/31/2020, indicated Resident 1 was moderately impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) in daily decision making skills. Resident 1 required one-person extensive assistance with dressing, and personal hygiene and two-person assistance with transfer from bed to wheelchair. 1. A review of Resident 1's General Acute Care Hospital (GACH) Wound Assessment notes, dated 8/23/2020, indicated left posterior ear, patches of dry thick flaky epidermis (a layer of skin covering the dermis), no purulence (pus). The wound was cleansed with normal saline (a salty solution used to clean debris from skin) and barrier film (a cream applied to protect skin) applied and open to air. A review of Resident 1's Wound Skin Doctor notes, dated 8/26/2020, indicated a right ear dry flaky skin with no odor, not infected and no pain. The plan indicated was to clean with normal saline followed by A & D ointment (a skin protectant that works by moisturizing and sealing the skin, and aids in skin healing and used to treat dry or chafed skin, and minor cuts or burns) daily as maintenance for seven days. There was no assessment documented for Resident 1's left ear. A review of Resident 1's Wound Skin Doctor Notes on 9/1/2020 indicated the right ear skin was resolved with no new orders. The Notes did not indicate any assessment for the left ear. During an observation on 9/2/2020 at 11:40 AM, together with the Licensed Vocation Nurse (LVN)1 who was also the treatment nurse, Resident 1's left ear and surrounding skin was observed with a rectangular patch of darkened skin approximately 1 centimeter (cm, unit of measurement) by 0.5 cm. In a concurrent interview, LVN 1 stated this was from when the resident had a nasal cannula (plastic tube from the oxygen concentrator to the nose. A nasal cannula is held in place by a plastic cord behind the ears) placed on her to receive oxygen in the GACH. The right ear was observed with mild redness but did not have any abnormal skin. LVN 1 stated there was no nursing documentation regarding Resident 1's left ear skin since return from the GACH on 8/26/2020. A review of Resident 1's physician's orders [REDACTED]. posterior (back part) ear was reassessed and noted to have a fungal infection. The SBAR indicated the wound doctor was made aware with new orders. During a telephone interview with the Director of Nurses (DON) on 9/11/2020 at 11:55 AM, she stated the wound care doctor assessed the left ear even though it was not documented on. But she was unable to answer why the antifungal cream was not started until 9/2/2020 the day LVN 1 became aware of the skin issue and six days after return from the GACH. The DON stated there was a wound care doctor assessment later in the day on 9/2/2020 and that there was an order for [REDACTED]. 2. A review of Resident 1's Podiatrist (a doctor who has been trained to diagnose and treat abnormal conditions of the feet and lower limbs) Physician's Notes, dated 9/20/2018, indicated Resident 1 had a history of [REDACTED]. The document indicated all toenails were debrided (removed damaged tissue) of any devitalized (dead) nail tissue, noting the nails appeared gryphotic (such as nail having a curvature) and symptomatic. These notes were the last documentation of care of the nails. Resident 1 visited the podiatrist on 11/27/2018, 12/27/2018, and 1/31/2019 but had refused care on those visits, according to Resident 1's Podiatrist Notes. A review of Resident 1's Interdisciplinary (IDT, a team of disciplines such as social services, nursing, nutrition, etc. who meet to plan care for a resident) Notes, dated 4/28/2020 and 6/15/2020 did not indicate any documentation regarding toe nails being trimmed. A review of Resident 1's General Acute Care Hospital (GACH) Social Worker's (GSW) Notes, dated 8/24/2020, indicated the Family Member 1 (FM 1) showed the GSW how long Resident 1's toe nails

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.

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) were. During an interview with the Director of Nursing (DON) on 9/11/2020 at 11:55 AM, she stated she was unsure when Resident 1 was last seen by a podiatrist. During a phone interview with the DON on 9/15/2020 at 9:45 AM, she stated that the licensed charge nurses cut a resident's nails but did not document since it was not a change in condition. The DON stated Resident 1 had aggressive behavior and kicks, and we had to go back when she was in a better mood. The DON stated there was no care plan regarding the cutting of Resident 1's toe nails, but will be developing one for the future. The DON was unable to provide any record of when Resident 1's toe nails were last cut or by which licensed staff. A review of the policy and procedure titled, Foot Care, reviewed on 1/31/2019, indicated that for In the care plan, document the need for foot care.