STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056082	A. BUILDING _____ B. WING _____	09/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CANYON SPRINGS POST-ACUTE	180 NORTH JACKSON AVENUE SAN JOSE, CA 95116

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 to ensure services were provided to prevent and heal pressure ulcers (damage to the skin as a result of prolonged pressure) for 1 of 3 residents (Resident 1) when: 1. The licensed nurses failed to properly assess and monitor Resident 1's pressure ulcer. 2. The licensed nurses failed to follow physician's orders [REDACTED]. These failures had the potential for not providing Resident 1 with the necessary treatment and interventions, and worsening of the pressure ulcer. Findings: 1. Review of Resident 1's clinical record, indicated she was an [AGE] year-old female admitted on [DATE], with [DIAGNOSES REDACTED]. Review of Resident 1's admission minimum data set (MDS, a clinical assessment tool), dated 7/31/19, indicated Resident 1 did not have a pressure ulcer on admission. Subsequent quarterly MDS, dated [DATE] and 1/6/2020, indicated no pressure ulcer. Review of Resident 1's MDS indicated she was cognitively (mental process) impaired with a BIMS (Brief Interview for Mental Status) score of four. She required extensive level of assistance with activities of daily living, and was incontinent of both bowel and bladder. Review of Resident 1's Braden Score (tool for predicting pressure ulcer), dated 7/24/19, indicated she was at mild risk for pressure ulcer (score of 18) on admission. The quarterly Braden Score, dated 10/21/19, and 1/17/2020, indicated she continued to be at mild risk with scores of 18 and 15 respectively. Review of Resident 1's Skin Care Plan initiated on 7/24/19, identified the resident as at risk for altered skin integrity, with interventions in place to include . daily skin checks, nutrition and hydration, alternating pressure pad (APP mattress), cushion for chair. Review of Resident 1's nursing progress notes, dated 10/22/19 at 14:30 (2:30 p.m.), indicated the certified nursing assistant (CNA) reported to the licensed nurse (LN), Resident 1 had a moisture associated skin damage (MASD, the general term for inflammation or skin erosion caused by prolonged exposure to a source of moisture (e.g., urine, feces, wound drainage, sweat) on the coccyx (tailbone)area. The MASD measured 0.5 centimeter (cm., unit of measure) (L, length)X 0.5 cm.(W, width). The LN notified the physician and obtained a treatment order, to apply a moisture barrier (Calazyme) after each episode of incontinence care every shift X 14 days (10/22/2020 to 11/5/2020) and re-evaluate. During a telephone interview with the director of nursing (DON) on 7/7/2020 at 11:59 a.m., she stated the MASD was off and on (not healing). She stated it would show on the TAR if the MASD healed. The DON confirmed there was no documentation the MASD healed or if they notified the physician for further evaluation and treatment of [REDACTED]. The registered nurse assessment indicated, partial thickness loss, pink wound bed, granulated tissue; 6 cm x 12 cm x 0 depth; no exudate; no odor; surrounding tissue with [DIAGNOSES REDACTED] (redness). It was classified as a Stage 2. The LN notified the physician with the following treatment orders: Cleanse site with NS (normal saline), pat dry, apply hydrogel (high water content gel provides a moist healing environment) and cover with foam dressing once a day. If dressing is soiled, leaking, or removed, then cleanse with NS, pat dry, apply hydrogel and cover with foam dressing. Report untoward changes to MD if there is any. During a telephone interview with the night shift, CNA E, on 7/16/2020 at 4:41 p.m., she stated she could not remember the dates she took care of Resident 1. She stated she remembered the wound appeared bigger, a little deep but with no odor. She stated when the dressing fell off, she informed the nurse (unable to recall nurse's name) to change the dressing. During an interview with CNA F, on 8/20/2020 at 9:50 a.m., she stated she took care of Resident 1 on 4/26/2020, on the evening shift. She stated there was a pressure ulcer in the coccyx area and it looked bad, but could not accurately describe the wound. CNA F stated she asked the nurse if she was aware of the wound, and the nurse said it was already noted. During an interview with CNA G, on 8/20/2020 at 10:20 a.m., she stated during the times she took care of Resident 1, there was redness in the buttocks area, like a scratch about to open. She informed the LN. The following day, it was open and Resident 1 had a treatment order every day. She recalled the wound got bigger and the nurse was aware. Review of subsequent nursing progress notes, indicated there was no follow-up assessment and documentation on the status of the sacral wound from 4/21/2020 to 4/24/2020. On 4/25/220 at 20:59 (8:59 p.m.), the LN documented, treatment done to buttocks as ordered . There was no mention or description of the wound. On 4/28/2020 at 5:25 a.m., the registered nurse (RN) documented, dressing was wet, dressing changed on sacral, brief also dry and intact after the change. There was no assessment and documentation of the sacral wound. During a telephone interview with LVN A on 7/7/2020 at 5:22 p.m., she stated they would do a 72 hour alert charting if there was a change in condition. After 72 hours, they do not have to document unless there is a change. She stated, on 4/24/2020 the wound looked the same so there was no need to document. During a telephone interview with LVN C on 7/9/2020 at 9:34 a.m., she stated the CNA would inform her if Resident 1 was wet and the wound dressing needed to be changed. She stated she followed the facility's policy, there was no need to document if there was no change from prior wound assessment. During a telephone interview with the DON on 7/9/2020 at 10:07 a.m., she stated the nurse with the CNA, do a head to toe assessment at start of shift. If there were changes, the nurse would notify the physician, document in the progress note, and start a 72 hour alert charting. The DON also stated they do a weekly summary, which includes a head to toe assessment, and a weekly progress notes for wound. She stated the nurse would create a wound event, and initiate a care plan. Review of Resident 1's Weekly Summary, Head to Toe Skin observations Conditions, dated 11/1/19 to 4/8/2020, indicated the skin was intact. There was no weekly summary done for April 15/2020 and April 22/2020. The DON confirmed these findings during a concurrent record review and interview on 8/20/2020 at 1:30 p.m. During a concurrent interview and record review with the ADON on 8/20/2020 at 11:15 a.m., she confirmed there was no 72 hour alert charting done from 4/21/2020 to 4/24/2020, after the Stage 2 in the sacral area was identified. She stated the nurse should have assessed and documented the wound appearance if they did the treatment, or when they changed the dressing if the resident was soiled, or wet. The ADON further stated the nurse should do a full assessment of the skin for accuracy, prior to documenting in the weekly summary. Review of the Resident 1's progress notes, dated 4/29/2020, indicated the nurse practitioner (NP, advanced practice registered nurse who has completed training in a specialty area of medicine) had seen and examined Resident 1. She ordered to transfer Resident 1 to the hospital for further evaluation and treatment of [REDACTED]. The NP assessment of Resident 1's pressure ulcer, indicated Stage 4 infected pressure sore on the sacro- coccyx area into bone area. It measured 8 cm(L) X 15 cm (W) and 3 cm (depth). The LN notifed the RP and the physician, who ordered the transfer to the hospital. 2. Review of Resident 1's nursing progress notes, dated 10/30/19 at 14:52 (2:52 p.m.), indicated an increase in size of the MASD in the coccyx area. It measured 0.6 centimeter cm. (L) X 0.8 cm (W) X 0.1 cm.(D, depth).It further indicated, wound bed with granulation tissue, wound edges well defined with surrounding area intact. There was no documentation the LN notified the physician, regarding the increase in size, and if it needed further evaluation. During a telephone interview with licensed vocational nurse A (LVN A) on 7/8/2020 at 5:04 p.m., she stated she did not remember calling the physician regarding an increase in size of the MASD and if there was a need for further evaluation. During a telephone interview with LVN B on 7/7/2020 at 4:24 p.m., she stated she could not remember the exact date, but she remembered the wound had a blackish area, unsure of size, but without odor and drainage. She stated she did not notify the physician, as there was already a treatment order in place. According to the assignment list provided by the DON, LVN B was assigned to Resident 1 on 4/28/2020 and 4/29/2020, the date Resident 1 was transferred to the hospital. Review of the TAR dated 4/10/2020 to 4/20/2020, indicated treatment was not documented as

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 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) done on the following dates: 4/10, days and evening shifts; 4/11, days and evening shifts; 4/13 and 4/14, evening shifts. During a concurrent interview with the ADON on 8/20/2020 at 11:15 a.m., she confirmed the findings above. She stated the nurse should have documented the treatment ordered and the reason if the treatment was not done. During a telephone interview with RN D on 8/24/2020 at 7:22 a.m., he stated when he looked at the wound, there was a brownish color over the wound. It's like a DTI (deep tissue injury, intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue). He stated he did not do any wound measurement, and did not report to the physician, because he assumed someone had already reported it to the physician. He stated should have reported it to the physician. During a telephone interview with Resident 1's physician on 8/25/2020 at 3:32 p.m., she stated the facility did not notify her of any changes in the pressure ulcer and acknowledged the nurse should have notified her of changes in the status of the wound. Review of Resident 1's Pressure Ulcer Care Plan, dated 4/20/2020, indicated interventions to include low air loss mattress (LALM, provide airflow to help keep skin dry, as well as relieve pressure), Wound care as ordered ,and Report any untoward changes to MD if there's any. Review of the facility's policy Pressure Ulcer/Injury Risk Assessment revised July 2017, indicated the effects of the intervention documentation in the resident's medical record should include . the type of assessment conducted, the date and time pf skin care provided, the condition of the resident's skin (i.e. the size and location of any redness or tender areas) if identified, any change in the resident's condition, MD notification if new skin alteration noted with change in plan of care. Review of the facility's policy Changes in a Resident's Condition or Status revised May 2017, indicated the nurse will notify the resident's Attending Physician or physician on call when there has been .specific instruction to notify the Physician of changes in the resident's condition.