STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055685	A. BUILDING _____ B. WING _____	**09/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRIGHTON PLACE SPRING VALLEY	**9009 CAMPO ROAD SPRING VALLEY, CA 91977**

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 ensure one of three residents (Resident 1) had a baseline written care plan for skin developed, to include a pressure injury (PI, localized damage to the skin and underlying soft tissue usually over a bony prominence as a result of prolonged pressure) to the left buttock. In addition, the baseline written care plan for skin did not include interventions that were individualized to address a UTD (unable to stage due to wound base being obscured by dead or devitalized tissue) PI on Resident 1's left heel. These failures had the potential for Resident 1's PI to worsen and thus impact the resident's quality of life. Findings: Resident 1 was admitted to the facility on [DATE], per the facility's Face Sheet. On 6/15/18 a record review was conducted. Resident 1's Resident Admission Assessment, dated 2/21/17, was reviewed. The skin assessment section had an anatomical figure of the human body with an X marked on the right and left buttock region. A letter L that was circled and the word buttocks was written next to an X. The admission skin assessment did not describe what the Xs represented, or how the abnormality presented. The skin assessment also noted, L (left) heel eschar (dead tissue) UTD. A review of the Medication Administration Record [REDACTED]. Resident 1's baseline written care plan for Skin condition noted on admission, dated 2/21/17, was reviewed. The written care plan did not identify the left buttock, which was currently treated with a [MEDICATION NAME] ointment, as a skin condition. On 6/15/18 at 2:56 P.M., a joint interview and record review was conducted with licensed nurse (LN) 1. LN 1 reviewed Resident 1's baseline written care plan for Skin condition noted on admission, dated 2/21/17. LN 1 stated all skin issues including the PI on the left buttock should have been developed as part of the baseline written care plan. LN 1 stated this should have been done within the resident's first 48 hours in the facility. LN 1 further stated Resident 1's L (left) heel eschar UTD was mentioned as a skin condition on the baseline written care plan. LN 1 stated the left heel did not have individualized interventions to alleviate pressure. LN 1 stated the baseline written care plan should have included interventions to float Resident 1's heel and apply a heel protector boot (pressure relieving device). LN 1 stated Resident 1 should have also had a low air-loss mattress (LAL a specialized mattress that redistributes pressure and is used to prevent new or worsening PI) provided as an intervention. LN 1 stated these interventions should have been developed when the baseline care plan was written on 2/21/17. On 6/15/18 at 3:27 P.M., a joint interview and record review was conducted with the director of nursing (DON). The DON reviewed Resident 1's baseline written care plan Skin condition noted on admission, dated 2/21/17. The DON stated Resident 1's baseline written care plan should have included the PI on the left buttock. The DON stated Resident 1's left buttock was being treated with a [MEDICATION NAME] ointment indicating the wound was at least a stage 3 PI (full-thickness skin loss in which fat is visible in the ulcer, slough and eschar may be present). The DON stated all PI present on admission should have been developed in the baseline written care plan. The DON also stated Resident 1's left heel UTD should have had interventions in the baseline care plan that included floating the heel and use of a heel protector boot. The DON further stated Resident 1 should have had a LAL mattress as an intervention because the resident had multiple PI. The DON stated having these interventions in place on the baseline care plan was important to ensure Resident 1's PI did not worsen. Per the facility's policy titled Comprehensive Person-Centered Care Planning, dated 11/2017, . a. The baseline care plan must include the minimum healthcare information necessary to properly care for each resident immediately upon their admission. It should address resident-specific health and safety concerns to prevent decline or injury . b. the baseline care plan will be completed and implemented within 48 hours of the resident's admission
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 one of three residents (Resident 1) received care consistent with professional standards of practice for the treatment and prevention of pressure injuries (PI, localized damage to the skin and underlying soft tissue usually over a bony prominence as a result of prolonged pressure), when: - Resident 1 did not receive a thorough and complete nursing skin assessment upon admission, and was not reassessed by the wound treatment nurse within the first 24 hours to the facility. - Resident 1 was not provided a low airloss mattress (LAL a specialized mattress that redistributes pressure and is used to prevent new or worsening PI) in a timely manner. - Resident 1's PI treatments were not consistently performed. These failures had the potential for Resident 1 to develop new or worsening PI. Findings: Resident 1 was admitted to the facility on [DATE], per the facility's Face Sheet. On 6/15/18, a record review was conducted. Resident 1's Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. Resident 1 was to receive daily wound treatments to the left buttock and left heel using a [MEDICATION NAME] ointment (medication used to remove devitalized or dead tissue) and covered with a clean dressing. The MAR indicated [REDACTED]. Resident 1 was also to receive daily wound treatments to the right shoulder and right thigh using hydrogel and covered with a clean dressing. The MAR indicated [REDACTED]. Resident 1's MAR for March 2017 was reviewed. Resident 1 was to receive daily wound treatments using a [MEDICATION NAME] ointment and covered with a clean dressing to the right humeral greater trochanter (upper arm), right greater trochanter (hip), right femur (thigh) on three sites, left superior gluteal fold (buttock), and sacral area. The MAR indicated [REDACTED]. The MAR indicated [REDACTED]. Resident 1 was also to receive daily wound treatment to the left heel using a wound cleanser, gauze soaked with [MEDICATION NAME] (antiseptic solution), and covered with dry gauze then wrapped. The MAR indicated [REDACTED]. Resident 1's Resident Admission Assessment, dated 2/21/17, was reviewed. The skin assessment section had an anatomical figure of the human body with an X marked on the right and left buttock region. A letter L that was circled and the word buttocks was written next to an X. The admission skin assessment did not describe what the Xs represented, nor were the Xs measured. On 6/15/18 at 2:56 P.M., a joint interview and record review was conducted with LN 1. LN 1 reviewed Resident 1's Resident Admission Assessment, dated 2/21/17, and stated the resident's skin assessment was incomplete and not thorough. LN 1 stated no one could tell what abnormal skin condition was present on the buttocks as they were only marked with an X. LN 1 stated all skin conditions and PI had to be clearly identified, described, and measured when assessed. LN 1 stated this was not done when Resident 1's skin was assessed upon admission to the facility. LN 1 further reviewed Resident 1's clinical record and stated the resident was not reassessed by the wound treatment nurse within 24 hours of admission. LN 1 stated it was considered a standard of (nursing) practice and it was the facility's policy for the wound treatment nurse to reassess residents' skin within 24 hours of admission. LN 1 stated Resident 1 had not had his wounds reassessed by the wound treatment nurse until six days after admission on 2/27/17. LN 1 reviewed Resident 1's Pressure Ulcer (PI) Site Sheet, dated 2/27/17, which had an anatomical human figure with a mark on the left buttock and had hand written portions filled out, Date of Onset: unknown, present on admission . (Circled) L (left) superior gluteal fold . stage 3 (PI wound that extends into the subcutaneous tissue)

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

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F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) circular size 2.0 x (by) 2.0 (centimeters) .3 (0.3 centimeters) depth, wound bed . with thin slough (devitalized tissue) 100 % . LN 1 stated when she compared Resident 1's admission skin assessment with wound nurse's assessment six days after admission, she could not tell if the wound had gotten worse or better. LN 1 stated the left buttock wound should have been clearly identified, described, and measured upon admission in order to determine if the wound was deteriorating or healing. LN 1 further stated when the wound treatment nurse reassessed Resident 1 on 2/27/17, there were multiple wounds identified as PI stage 3 or unstageable (unable to stage due to wound base being obscured by devitalized tissue) on the right upper arm, three sites on the right thigh, right hip, sacral area, and left heel. LN 1 stated, That's a lot of pressure ulcers. And bad ones. LN 1 stated Resident 1 should have been provided a LAL mattress to promote healing and prevent worsening of the PI. LN 1 stated she could not find documentation Resident 1 was provided a LAL mattress until 3/15/17. LN 1 stated Resident 1 should have had a LAL mattress when admitted to the facility on [DATE]. LN 1 reviewed Resident 1's clinical chart and stated there was no documentation the facility's Interdisciplinary Team (IDT) met to discuss the residents skin issues and PI. LN 1 stated this should have been done. LN 1 reviewed Resident 1's MAR for February 2017. LN 1 stated the MAR indicated [REDACTED]. LN 1 stated the physician's orders [REDACTED]. LN 1 stated when the MAR indicated [REDACTED]. LN 1 stated physician treatment orders were supposed to be followed. LN 1 further stated consistent wound treatments were an important part of wound healing. On 6/15/18 at 3:27 P.M., a joint interview and record review was conducted with the director of nursing (DON). The DON reviewed Resident 1's Resident Admission Assessment, dated 2/21/17, and stated the resident's skin assessment did not have a clear description with measurements of all wounds. The DON stated marking an X and not describing the skin abnormality, was an unacceptable nursing assessment. The DON stated it was her expectation for nurses to conduct clear, accurate, and descriptive assessments. The DON stated the treatment for [REDACTED]. The DON stated Resident 1's wound on the left buttock should have been staged as a PI in the nursing admission assessment. The DON stated an accurate nursing assessment was important to ensure wound treatment was appropriate as well as to monitor the progression of the wound. The DON reviewed Resident 1's clinical record and stated providing the resident with a LAL mattress on 3/15/17 was not timely. The DON stated Resident 1 should have been provided a LAL mattress upon admission (2/21/17) as he had multiple wounds including a sacral PI as well as an ustageable PI with noted eschar (dead tissue) to the left heel. The DON stated a LAL mattress was an intervention to prevent the development of new PI or the worsening of existing PI. On 7/30/18 at 11:50 A.M., a joint interview and record review was conducted with LN 2. LN 2 reviewed Resident 1's MAR for February and March 2017. LN 2 stated Resident 1 did not receive his physician ordered wound treatments on 2/25, 3/1, 3/5, 3/6, 3/7, 3/9, 3/10, and 3/11. LN 2 stated, If you didn't sign it (MAR), you didn't do it (the treatment). LN 2 reviewed Resident 1's clinical record and stated there was no documentation the resident refused wound treatment or was out of the facility on the days the MAR indicated [REDACTED]. On 7/30/18 at 2 P.M., an interview was conducted with the DON. The DON stated it was her expectation for the wound treatment nurse to reassess all newly admitted residents within 24 hours of admission. The DON stated Resident 1 should have had his wounds reassessed by the treatment nurse within 24 hours of being admitted to the facility. The DON stated it was her expectation for wound treatments to be consistently performed as ordered by the physician. The DON stated Resident 1 should not have missed wound treatments on 2/25, 3/1, 3/5, 3/6, 3/7, 3/9, 3/10, and 3/11 in 2017. The facility's policy titled Pressure Injury and Skin Integrity Treatment, revised 8/12/16, did not provide guidance for nursing skin and PI assessments, wound treatment nurse responsibilities, PI interventions, or carrying out wound treatment orders.