STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056362	A. BUILDING _____ B. WING _____	07/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MESA VERDE POST ACUTE CARE CENTER	661 CENTER STREET COSTA MESA, CA 92627

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 medical record review, the facility failed to provide the necessary treatment and services to prevent the development of a pressure ulcer for one of two sampled residents (Resident 1). Resident 1 had a history of [REDACTED]. * On 2/8 and 2/29/20, Resident 1 was identified to have redness to the mid back. There was no documented evidence of assessment or interventions. * On 3/8/20, Resident 1 developed an open area on the mid back which had redness, swelling, and serosanquinous drainage. * On 3/12/20, Resident 1's mid back was assessed as a pressure ulcer with 100 percent necrotic (dead) tissue by the Wound Care Specialist. The facility's failure to act upon the identified redness and provide adequate interventions caused Resident 1 to develop a Stage 4 pressure ulcer (full thickness skin loss with exposed bone, tendon, or muscle). Findings: Closed medical record review for Resident 1 was initiated on 6/11/20. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's Admission assessment dated [DATE], showed no evidence of pressure ulcers or skin breakdown upon admission to the facility. Review of Patient Inquiry (information obtained by the facility prior to admission) dated 2/7/18, showed Resident 1 had a history of [REDACTED]. Review of Resident 1's Braden Scale - For Predicting Pressure Sore Risk dated 11/2/18, 2/19, 5/3, 8/12/19, 2/4 and 3/9/20, showed Resident 1 was a high risk for developing a pressure ulcer. Review of Resident 1's plan of care showed a care plan problem to address the risk for skin breakdown was initiated on 2/26/18. The interventions included to provide care and reposition with care rounds, provide pressure redistributing devices and assess for effectiveness, and provide skin care frequently. The care plan problem showed it had been reviewed every three months with no changes until 3/8/20, when Resident 1 developed a pressure ulcer on the mid back. On 6/18/20 at 0936 hours, a telephone interview was conducted with CNA 1. CNA 1 stated Resident 1 was dependent on staff for all care needs. CNA 1 stated Resident 1 was repositioned every two hours to the right and left side using pillows. CNA 1 stated Resident 1 was unable to move any part of his body. Review of the Weekly Summary for Resident 1 dated 2/8 and 2/29/20, showed Resident 1 had redness to the mid back. Resident 1's medical record showed no other Weekly Summaries were completed for February 2020. On 7/2/20 at 1129 hours, a telephone interview and concurrent closed medical record review was conducted with LVN 1. LVN 1 verified she completed Resident 1's Weekly Summary on 2/8 and 2/29/20. LVN 1 stated when a resident had a Weekly Summary done, the LVN and the CNA assigned to the resident would check the resident's skin together. The Weekly Summary dated 2/8/20, was reviewed with LVN 1. LVN 1 stated she recalled Resident 1 had redness on the back. LVN 1 stated Resident 1 did not look comfortable in the wheelchair and could have caused the redness. LVN 1 stated a Change of Condition form was completed. The Weekly Summary dated 2/29/20, was reviewed with LVN 1, LVN 1 stated there was an area of intact but red skin to Resident 1's back, which measured about the size of a person's palm of their hand. LVN 1 stated Resident 1 had a curvature of the spine, and the bony spinal process could be seen under the skin. LVN 1 stated they informed the Treatment Nurse. LVN 1 stated the Treatment Nurse would have assessed Resident 1, notify the physician, and obtain the treatment orders if needed. LVN 1 stated they did not recall Resident 1 having pressure ulcers in the past. On 7/2/20 at 1318 hours, a telephone interview was conducted with the DON. The DON was asked for Resident 1's Change of Condition forms for February 2020. The DON was unable to find any. Review of Resident 1's Change in Condition form dated 3/8/20, showed Resident 1 had a red open skin area on the mid-back. Review of Resident 1's Non-Pressure Sore Skin Problem Report dated 3/8/20, showed an open skin area to the mid back, with surrounding swelling and minimal serosanquinous drainage. The measurement was 4.5 cm (length) and 3.5 cm (width). On 7/2/20 at 1408 hours, a telephone interview was conducted with LVN 4. LVN 4 verified they had completed the Change of Condition form dated 3/8/20. LVN 4 stated if recalled correctly, the CNA had informed LVN 4 of the wound on Resident 1's back. LVN 4 stated they recalled the wound on Resident 1's back was open and discolored, possibly red. Review of Resident 1's physicians' orders showed the following orders were received on: - 3/8/20, cleanse the mid back open wound with normal saline (a saline solution), pat dry, apply a Vaseline gauze and cover with a dry dressing. - 3/9/20, a low air loss mattress (a specialized mattress to help reduce pressure). - 3/11/20, a consultation with a Wound Care Specialist. - 3/19/20, side to side positioning only, offload back wound at all times. Review of the Wound Care Consult Note dated 3/12/20, showed Resident 1's wound on her back was caused by pressure, and had 100 percent necrotic (dead) tissue. The necrotic tissue was debrided and after debridement the pressure ulcer was assessed as Stage 4 measuring 9 cm (length) x 7.5 cm (width) x 1 cm (depth). Review of the Wound Care Follow-Up Note dated 3/19/20, showed Resident 1's pressure ulcer was reclassified as a re-opened Stage 4 pressure wound. On 7/2/20 at 1030 hours and 7/7/20 at 1600 hours, a telephone interview and concurrent closed medical record review was conducted with LVN 3. LVN 3 was asked what was the facility's process when a CNA reports a resident has a reddened area on the skin. LVN 3 stated the licensed nurse would assess the resident's skin, if necessary complete a Change of Condition form, notify the physician, and the resident's responsible party. LVN 3 stated Resident 1's back wound was open on 3/8/2 and the wound bed was pinkish/red with serosanquinous drainage. LVN 3 stated they performed wound care e treatment daily and the Wound Care Specialist evaluated Resident 1 on 3/12/20. LVN 3 was asked if Resident 1's wound had necrotic tissues. LVN 3 stated they were unsure of what necrotic tissue looked like. However, after LVN 3 was informed of the description of necrotic tissue, LVN 3 stated the wound had become brown in color on 3/11/20, and staff could no long see the wound bed or the depth. LVN 3 stated the Wound Care Specialist debrided Resident 1's wound on 3/12/20 and verified the Wound Care Consult Note dated 3/12/20, which showed Resident 1's back wound was caused by pressure, had 100% necrotic tissue and the depth was to the bone. LVN 3 stated they were unaware Resident 1 had redness to the back on 2/8 and 2/29/20.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility document review, the facility failed to adequately supervise one of two sampled residents (Resident 1) to prevent a fall. Resident 1 had an unwitnessed fall from the bed, falling head first to the floor. This failure resulted in Resident 1 sustaining a subdural hematoma and acute care hospitalization . Findings: Closed medical record review for Resident 1 was initiated on 6/11/20. Resident 1 was admitted to the facility on [DATE], and was discharged to the acute care hospital on [DATE]. Review of Resident 1's history and physical examination [REDACTED]. Review of Resident 1's MDS dated [DATE], showed Resident 1 was totally dependent to two or more staff for bed mobility and transfers. Review of Resident 1's plan of care showed a care plan to address Resident was at risk for fall was developed on 2/28/18. On 7/10/18, a care plan problem to address Resident 1 slipping out of the bed was added. The interventions included to ensure the bed was at the lowest possible position and floor mats on both sides of the bed. Review of the Falls SBAR dated 4/12/10, showed Resident 1's physician was notified at 2030 hours regarding Resident 1 was found with his head on the floor, with both feet on the bed. Resident 1 sustained a bleeding skin tear to the forehead and

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

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) abrasion to the right shoulder. The physician ordered Resident 1 to be transferred to the emergency department for further evaluation. On 6/11/20 at 1145 hours, an interview was conducted with the DON. The DON stated Resident 1 was on a special mattress with bolsters on both sides of the bed. The DON stated Resident 1 had no history of falls for some time. The DON was asked why Resident 1 did not have floor mats next to the bed. The DON stated Resident 1's roommate was always moving around in the room using a wheelchair, and having floor mats would leave little space for Resident 1's roommate to move about safely. On 6/18/20 at 0936 hours, a telephone interview was conducted with CNA 1. CNA 1 stated Resident 1 was dependent on staff for all care needs. CNA 1 stated Resident 1 was repositioned every two hours to the right and left side using pillows. CNA 1 stated Resident 1 was unable to move any part of the body. CNA 1 stated on 4/12/20 between 1800-1830 hours, Resident 1 was positioned on the back, the head of the bed was elevated to a sitting position, and was provided assistance with eating. CNA 1 stated after Resident 1 had finished eating, the resident's bed was placed in low position, the head of the bed was slightly elevated, and the pillows were placed on each side of the resident's body. CNA 1 could not recall if Resident 1 had floor mats next to the bed. CNA 1 stated she had taken a break at 1900 hours after she had respositioned the resident. CNA 1 was asked if they had seen Resident 1 after returning from break, CNA 1 stated no. CNA 1 stated it was the Charge Nurse who had notified her that Resident 1 had fallen. On 6/22/20 at 1543 hours, a telephone interview was conducted with LVN 2. LVN 2 stated they were in the hallway passing medication on 4/12/20, when they heard a loud noise, which sounded like someone or something had fallen to the floor. LVN 2 stated Resident 1 was on a low air loss mattress (a specialty mattress used for pressure reduction) with bolster pillows on each side of the mattress and pillows for positioning. The bed was in the low position and the head of the bed was elevated to approximately 35 degrees when the fall occurred. LVN 2 stated there were no mats on the floor next to Resident 1's bed. LVN 2 stated he had seen Resident 1 two times prior to the fall. LVN 2 stated he checked Resident 1 for proper positioning in the center of the bed. LVN 2 stated Resident 1 had contractures of the arms and legs and was non-verbal. Review of Resident 1's acute care hospital medical record showed on 4/12/20, a CT of the head, which showed a subdural hematoma.