STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555004	A. BUILDING _____ B. WING _____	**07/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PLAYA DEL REY CENTER	**7716 MANCHESTER AVENUE PLAYA DEL REY, CA 90293**

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 0580 **Level of harm -** Actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to notify a physician when one of three sampled residents (Resident 3) had a change of condition ((COC) sudden, clinical deviation from a resident's baseline) on 6/5/2020. Resident 3 had a skin condition that caused severe pain, itching and inability to sleep, which resulted in Resident 3 picking and scratching his skin all over his body. This deficient practice resulted in a 6-day delay in [DIAGNOSES REDACTED]. Resident 3 suffered undue pain, itching and mental anguish and inability to sleep at night and resulted in opened wounds with bleeding that had the potential to become infected (occurs when germs, such as bacteria, grow within the damaged skin of a wound). Findings: A review of Resident 3's Face Sheet (Admission Record) indicated the facility admitted the resident on 6/5/2020. Resident 3's [DIAGNOSES REDACTED]. A review of Resident 3's Licensed Progress note, dated 6/5/2020 and timed at 7:10 p.m. indicated Resident 3 was admitted to the facility with a Stage III sacral wound (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because of obscured by slough (shedding of dead tissue) or eschar (a dry, dark scab of dead skin)) and discoloration to upper and lower bilateral (both) extremities. A review of Resident 3's Weekly Bath and Skin Report, dated 6/8/2020 indicated Resident 3 was noted with open wounds on bilateral forearms, right knee, right foot and sacral area. The report indicated the charge nurse was notified of Resident 3's opened wounds. The note did not indicate Resident 3's physician was notified. A review of Resident 3's care plans, did not indicate a care plan was initiated on 6/8/2020 when the multiple wounds were identified by the staff and/or any physician notification of Resident 3's opened wounds. On 6/11/2020 at 10 a.m., during an observation of Resident 3's wounds and a concurrent interview, Licensed Vocational Nurse 2 (LVN 2) stated Resident 3's sacral wound had not been treated because she was passing medications. Resident 3 was observed moaning unable to answer any questions with generalized body discoloration purple/black in color, dry blood on arms, fingernails, face, bed linens, the wall and bed rails. LVN 2 stated of not being aware how Resident 3 sustained the skin injuries but was aware the resident had a behavior of picking his skin. LVN 2 stated Registered Nurse 1 (RN 1) was aware of Resident 3's skin injuries. On 6/11/2020 at 10:10 a.m., during an observation and interview of Resident 3 with RN 1 stated Resident 3 was admitted to the facility with the behavior of picking/scratching his skin causing skin tears. RN 1 stated Resident 3 had no care treatment ordered for the resident's skin injuries. A review of Resident 3's Licensed Progress notes, dated 6/5/2020 through 6/11/2020 did not indicate the resident's physician was notified of Resident 3's opened skin areas from severe itching and pain. A review of Resident 3's Treatment Assessment Record (TAR) and Medication Administration Record [REDACTED]. On 6/11/2020 at 4:20 p.m., during an interview and review of Resident 3's physician orders, Treatment Assessment Record (TAR) and care plans, RN 1 stated there was no care plan to address Resident 3's self-inflicting injuries or an assessment conducted. RN 1 stated being aware of Resident 3's itching since 6/5/2020 upon admission but failed to notify the physician because, I was too busy and did not have time. RN 1 stated she forgot to do treatment orders for Resident 3. On 6/12/2020 at 12:40 p.m., during an observation and interview, Resident 3 was seen scratching himself. Resident 3 stated his skin was itchy and painful. Resident 3 stated he informed the nurses of the skin pain with itching, but no medication was offered. Resident 3 stated the pain and itching was horrible and it would prevent him from sleeping at night. A review of Resident 3's dermatologist (branch of medicine dealing with the care of the skin) report, dated 6/12/2020 indicated Resident 3 had been complaining of blisters (small bubble on the skin filled with fluid) all over the body that had been flaring up for weeks. The dermatologist report indicated Resident 3 was diagnosed with [REDACTED]. The dermatologist report indicated to treat Resident 3 with [MEDICATION NAME] (an antibiotic) 100 micrograms (mcg (unit of measurement)) capsules by mouth three times a day and [MEDICATION NAME] (used to treat inflammation (the body's response to injury) and allergic conditions) 60 milligrams (mg) by mouth once a day for five days then decrease the dosage by 10 mg every five days for a total of 30 days. A review of an online Mayo Clinic article titled, [DIAGNOSES REDACTED] dated 12/4/18 indicated Pemphigoid was common in elder adults and could be life-threatening when in poor health. According to the article, Pemphigoid was categorized by large reddish dark blisters that are painful and sensitive when rupture or touched. On 6/14/2020 at 1 p.m., during an interview and review of Residents 3's clinical record (care plans, TARs, nurses notes, COC, physician orders, Activities of Daily Living (ADL) sheets) the Center Nurse Executive ((CNE) another name for director of nurse) stated and confirm the facility's staff did not follow the policy for wounds and the staff was responsible to assess, document, and carried out orders for residents. A review of the facility's P/P revised on 11/1/19 and titled, Assessment: Nursing, indicated an initial assessment was conducted to determine resident's condition and clinical needs. Upon the resident's admission, the licensed nurse would conduct a change in condition assessment as needed and notify physician of assessment findings.
F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow its policy and procedure (P/P), titled Abuse Prohibition, to ensure one of three sampled residents (Resident 3) was free of neglect and received necessary care and services to treat his skin wounds. Resident 3 had a skin condition that caused severe pain and itching that the facility failed to address and notified the physician, which resulted in Resident 3 picking and scratching his skin all over his body (crossed referenced to F580). This deficient practice of the facility neglecting Resident 3's [DIAGNOSES REDACTED] (rare skin condition causing large fluid-filled blisters) all over the body condition with severe pain and itching for over 6 days without any care and treatment resulting in self-inflicting wounds and sores all over the body. The resident suffered undue pain, itching and mental anguish and the inability to sleep at night and resulted in opened wounds with bleeding that had the potential to become infected (occurs when germs, such as bacteria, grow within the damaged skin of a wound). Findings: A review of Resident 3's Face Sheet (Admission Record) indicated the facility admitted the resident on 6/5/2020. Resident 3's [DIAGNOSES REDACTED]. A review of Resident 3's Licensed Progress note, dated 6/5/2020 and timed at 7:10 p.m. indicated Resident 3 was admitted to the facility with a Stage III sacral wound (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because of obscured by slough (shedding of dead tissue) or eschar (a dry, dark scab of dead skin)) and discoloration to upper and lower bilateral (both) extremities. A review of Resident 3's Licensed Progress notes, dated 6/5/2020 through 6/11/2020 did not indicate the resident's physician was notified of Resident 3's opened skin areas from severe itching and pain. A review of Resident 3's

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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 0600 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) care plans, did not indicate a care plan was initiated upon admission on 6/5/2020 or/on 6/8/2020 when the multiple wounds were identified by the staff and/or any physician notification of Resident 3's opened wounds. A review of Resident 3's Weekly Bath and Skin Report, dated 6/8/2020 indicated Resident 3 was noted with open wounds on bilateral forearms, right knee, right foot and sacral area. The report indicated the charge nurse was notified of Resident 3's opened wounds. The note did not indicate Resident 3's physician was notified. A review of Resident 3's Treatment Assessment Record (TAR) for the month of June 2020 did not indicate wound care treatment was being provided to the resident for the pain and itching of the skin. A review of an online Mayo Clinic article titled, [DIAGNOSES REDACTED] dated 12/4/18 indicated Pemphigoid was common in elder adults and was life-threatening when in poor health. According to the article, Pemphigoid was categorized by large reddish dark blisters that are painful and sensitive when rupture or touched. On 6/11/2020 at 10 a.m., during an observation of Resident 3's wounds and a concurrent interview, Licensed Vocational Nurse 2 (LVN 2) stated Resident 3's sacral wound had not been treated because she was passing medications. Resident 3 was observed moaning unable to answer any questions when asked about his pain level. Resident 3 had generalized body discoloration of purple/black in color, dry blood on arms, fingernails, face, bed linens, the wall and bed rails. LVN 2 stated of not being aware how Resident 3 sustained the skin injuries but was aware the resident had a behavior of picking his skin. LVN 2 stated Registered Nurse 1 (RN 1) was aware of Resident 3's skin injuries. A review of Resident 3's dermatologist (branch of medicine dealing with the care of the skin) report, dated 6/12/2020 indicated Resident 3 had been complaining of blisters (small bubble on the skin filled with fluid) all over the body that had been flaring up for weeks with pain. The dermatologist report indicated Resident 3 was diagnosed with [REDACTED]. The dermatologist report indicated to treat Resident 3 with [MEDICATION NAME] (an antibiotic) 100 micrograms (mcg (unit of measurement)) capsules by mouth three times a day and [MEDICATION NAME] (used to treat inflammation (the body's response to injury) and allergic conditions) 60 milligrams (mg) by mouth once a day for five days then decrease the dosage by 10 mg every five days for a total of 30 days. On 6/11/2020 at 10:10 a.m., during an observation and interview regarding Resident 3's generalized skin injuries with RN 1, RN 1 stated Resident 3 was admitted to the facility with behavior of picking/scratching his skin causing skin tears. RN 1 stated Resident 3 had no care treatment ordered for the resident's skin injuries. On 6/11/2020 at 4:20 p.m., during an interview and review of Resident 3's physician orders, Treatment Assessment Record (TAR) and care plans, RN 1 stated there was no care plan to address Resident 3's self-inflicting injuries or an assessment conducted. RN 1 stated being aware of Resident 3's itching since 6/5/2020 upon admission but failed to notify the physician because, I was too busy and did not have time. RN 1 stated she forgot to do treatment orders for Resident 3. On 6/12/2020 at 12:40 p.m., during an observation and interview, Resident 3 was seen scratching himself. Resident 3 stated his skin was itchy and painful. Resident 3 stated he informed the nurses of the skin pain with itching, but no medication was offered. Resident 3 stated the pain and itching was horrible and it would prevent him from sleeping at night. On 6/14/2020 at 1 p.m., during an interview and review of Residents 3's clinical record (care plans, TARs, nurses' notes, Change of Condition (COC), physician orders, Activities of Daily Living (ADL) sheets) the Center Nurse Executive (CNE (another name for director of nurses)) stated and confirm the facility's staff did not follow the policy for wounds and the staff was responsible to assess, document, and carried out orders for residents. A review of the facility's policy and procedure, revised on 7/1/19 and titled, Abuse Prohibition, indicated neglect was defined as the failure of the center, its employees, or service providers to provide goods and services to a patient that are necessary to avoid physical harm, mental anguish, or emotional distress.
F 0655 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop/implement and revised a baseline person-centered care plan for three of three sampled residents (Residents 1, 3 and 4). Resident 1 develop a three (3) centimeter ((cm) units of measurement) sacrum (tailbone) wound on 4/29/2020, which worsen and became infected (contaminated with a harmful organism) requiring Resident 1 had to be transfer to the general acute care hospital (GACH) for treatment. Resident 1's wound was reported to the physician on 4/29/2020 and order for treatment was not carried-out until 5/2/2020 (3 days later). Resident 3's Stage III sacrum (tail bone) pressure ulcer (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because of obscured by slough (shedding of dead tissue) or eschar (a dry, dark scab of dead skin)) that worsen to a Stage IV (full-thickness skin loss with extensive destruction; tissue necrosis, damage to muscle, bone, or supporting structure). Resident 3 did not receive wound care treatment for [REDACTED]. Care plan dated 6/6/2020 was not followed. Resident 4 developed a sacrum Stage II (partial thickness skin loss involving the epidermis and/or dermis) wound and treatment initiated on 5/12/2020. This deficient practices of not developing a baseline person-centered care plan identifying the care Residents 1, 3 and 4 needed, resulted in Resident 1 not receiving the care and services to prevent the development and worsening of a 3 cm sacrum ulcer; Resident 3's Stage III sacrum ulcer worsen to a Stage IV; and Resident 4 developing a sacrum Stage II ulcer. Findings: a. A review of Resident 1's Face Sheet (Admission Record) indicated the facility first admitted the resident on 1/14/11 and was last readmitted on [DATE]. Resident 1's [DIAGNOSES REDACTED]. [MEDICAL CONDITION] (paralysis on one side of the body) affecting right dominant (most important) side of the body. A review of Resident 1's Minimum Data Set (MDS), a resident assessment and care-screening tool, dated 3/8/2020 indicated the resident was sometimes understood and sometimes understand others. The MDS indicated the resident was totally dependent requiring a two or more-person physical assist for bed mobility (how the resident moves to and from lying position, turning side to side, and positioning of body) and a one-person physical assist for personal hygiene. The MDS indicated Resident 1 was always incontinent of bowel and bladder (lack of voluntary control) and had limited range of motion on one side of upper extremities and impairment of bilateral (both) lower extremities. The MDS indicated Resident 1 did not have pressure ulcers upon admission but was at risk to develop them. A review of Resident 1's Braden Scale (scale for predicting pressure sores), dated 12/10/19 indicated Resident 1's score for pressure ulcers development was moderate risk with a total score of 13. A review of Resident 1's care plan titled, Skin Breakdown, with revised date of 3/15/15 indicated Resident 1 was at risk for skin break due to impaired sensation, limited mobility and history of pressure ulcer. The care plan goal Resident 1 not to show signs of skin breakdown. The staffs' interventions included to evaluate and monitor for any localized skin problems, such as dryness, redness, pustules (small blister or pimple on the skin containing pus) and inflammation. The staff to observe skin condition and report abnormalities to primary physician. A review of Resident 1's nurses notes from 4/29/2020 through 5/7/2020, did not indicate a pressure relieving device was provided on Resident 1's bed and no documented evidence Resident 1's physician was notified of the resident's wound worsening. A review of Resident 1's nurses notes from 4/29/2020 through 6/2020 did not indicate a baseline care plan was created to identified staff interventions to prevent the worsening of the sacral ulcer. A review of Resident 1's Change of Condition ((COC) decline or improvement in a resident's mental or physical functioning) dated 4/29/2020 and timed at 11:12 a.m. indicated the resident was assessed with [REDACTED]. The nurse's note indicated the physician was notified and no new orders given. On 6/11/2020 at 11:58 a.m., during an interview and review of Resident 1's clinical chart, Registered Nurse 1 (RN 1) stated first informing Resident 1's primary physician on 4/30/2020. RN 1 stated no orders were carried out until 5/2/2020, three (3) days after the wound was identified. RN 1 stated the wound consult ordered on [DATE] was not carried out. RN 1 stated it was the responsibility of the treatment nurse to assess and document the status of the wound. The RN 1 stated no documentation of Resident 1's wound assessment was done, and no care plan created for the wound identified on 4/29/2020. On 6/11/2020 at 1:20 p.m., during an interview and review of Resident 1's record with the CNE and the MDSN, the MDSN stated Resident 1's Stage II sacral ulcer was identified on 4/29/2020 and physician orders [REDACTED]. The MDSN stated no wound treatments were done on 4/29/2020 through 5/1/2020. The MDSN stated no there was no wound assessments and or IDT done or found in Resident 1's clinical chart. The MDSN stated the Licensed Nurse fail to enter the physician's orders [REDACTED]. b. A review of Resident 3's Face Sheet (Admission Record) indicated the facility admitted the resident on 6/5/2020. Resident 3's [DIAGNOSES REDACTED]. A review of Resident 3's Braden Scale, dated 6/5/2020 indicated Resident 3's score for pressure sores development was moderate risk with a total score of 18. A review of Resident 3's care plan titled, Resident has Actual Skin Breakdown on Sacral Area, dated 6/6/2020. The goal was for the resident's sacral ulcer to decrease in size and heal. The staffs' interventions included to evaluate and monitor for any localized skin problems such as dryness, redness, pustules and inflammation, observe skin condition, provide treatments as order, care and report abnormalities to primary physician. A review of Resident 3's Licensed Progress note, dated 6/5/2020

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F 0655 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) and timed at 7:10 p.m. indicated Resident 3 was admitted to the facility with a Stage III sacral wound. On 6/11/2020 at 4:20 p.m., during an interview and review or Resident 3's care plans and TARs, the RN 1 indicated being aware Resident 3 was admitted with sacral ulcer but fail to initiate a care plan for interventions to prevent the wound from worsening. RN 1 also stated she did not enter the wound treatment orders because, I was too busy and did not have time. RN 1 stated she forgot to do treatment orders for Resident 3. c. A review of Resident 4's Face Sheet (Admission Record) indicated the facility first admitted the resident on 2/20/2020 and was last readmitted on [DATE]. Resident 4's [DIAGNOSES REDACTED]. A review of Resident 4's MDS dated [DATE] indicated the resident sometimes understood and understand others. The MDS indicated Resident 4 required extensive assist of a one-person physical assist for bed mobility. The MDS indicated Resident 4 was always incontinent of bowel and had impairment of bilateral lower extremities. The MDS indicated Resident 4 had two (2) pressure ulcers. A review of Resident 4's Braden Scale, dated 4/7/2020 indicated Resident 4's score for pressure sores development was moderate risk with a total score of 16. A review of Resident 4's skin assessment, dated 4/7/2020 indicated the resident did not have sacrum wounds. A review of Resident 4's care plans did not indicate a plan of care for the sacral ulcer was created on 5/11/2020 when the wound was identified. A review of Resident 4's Licensed Progress note, dated 5/19/2020 and timed at 5:29 p.m. indicated Resident 4 was noted with a sacral ulcer measuring 10 cm in L x 8 cm in W and no depth. On 6/14/2020 at 1 p.m., during an interview and review of Residents 1, 3 and 4 clinical records (care plans, TARs, nurses notes, COC, physician orders, ADL sheets) indicated the CNE stated and confirm the facility's staff did not follow the policy for wounds and the staff was responsible to assess, document, and carried out orders for residents. The CNE stated Residents 1 and 4 develop sacral wounds that worsen in the facility and Resident 3's sacral wound worsens in the facility. The CNE stated the staff fail to notify the resident's physician, create and update care plan, prevent development/worsening of sacral wounds and provide treatment as order by the primary physician. The CNE stated she was not made aware of the wounds because she was focus on the COVID (virus) residents. The review of the facility's policy and procedures (P/P) titled, Person-Center Care Plan revised 7/1/19 indicated a baseline person-centered care plan would be created within 48 hours for each patient admission that includes the instructions needed to provide effective and person-centered care that meet professional standards of quality care.
F 0686 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide the necessary care and services such as treatments, assessment, daily monitoring of pressure ulcers (prolonged pressure on the skin that results in injury to the skin and underlying tissue), to prevent the development and worsening of pressure ulcers for three of four sampled residents (Residents 1, 3 and 4). (Cross referenced to F655). Resident 1 developed a three (3) centimeter ((cm) units of measurement) sacrum (tailbone) wound on 4/29/2020, which worsen and became infected (contaminated with a harmful organism) requiring Resident 1 to be transfer to the general acute care hospital (GACH) for treatment. Resident 1's wound was reported to the physician on 4/29/2020 and order for treatment was not carried-out until 5/2/2020 (3 days later). Resident 3's Stage III sacrum pressure ulcer (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because of obscured by slough (shedding of dead tissue) or eschar (a dry, dark scab of dead skin)) that worsen to a Stage IV (full-thickness skin loss with extensive destruction; tissue necrosis, damage to muscle, bone, or supporting structure) according to the dermatologist assessment on 6/12/2020. Resident 3 did not receive wound care treatment for [REDACTED]. Resident 4 developed a sacrum Stage II (skin opened, wears away, or forms an ulcer, which is usually tender and painful; looks like a scrape (abrasion), blister, or a shallow crater in the skin) wound and treatment initiated on 5/12/2020. These deficient practices resulted in a delay in care and treatment for [REDACTED]. On 6/11/2020 at 5:41 p.m., the Center Nurse Executive (CNE) and the Minimum Data Set Nurse (MDSN), were notified of an Immediate Jeopardy ((IJ), a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was called for the facility's inability to provide the necessary care and services such as treatments, assessment, daily monitoring of pressure ulcers to prevent the development and worsening of pressure ulcer, development/evaluation of care plans and notification of the physician to manage a resident's pain and wound's condition, development and worsening condition of existing pressure ulcer. The facility's CNE and MDSN were notified of the immediacy and seriousness of the residents' health and safety being threatened. On 6/13/2020 at 1:15 p.m., the CNE and MDSN submitted an acceptable Plan of Action (POA) for the correction of the IJ which included: 1. Should Resident 1 return to the facility a skin assessment would be perform upon readmission, wound treatment orders and care plan will be added for any wounds. A wound care consult and notification to the physician will be made. 2. Resident 3's physician assessed the resident on 6/12/2020 and prescribed medication to assist with the itchiness and order a dermatologist (branch of medicine that treats skin conditions) consult. 3. On 6/11/2020, a designated charge nurse started a skin sweep to identify worsening of wounds and if any noted, the physician would be notified for new orders. 4. On 6/12/2020, a second skin sweep would be conducted by the wound physician and nurse to identify any new or worsening wounds. 5. The CNE and MDSN will create and revise any wound care plans of the residents identified. Medical Records staff will ensure residents have a base line care plan for new admissions. 5. Weekly skin wound reports to be provided to the CNE by the care nurse. 6. The Nurse Educator began in-servicing licensed nurses on 6/11/2020 and 6/12/2020 on care plans, neglect/abuse, wound assessment, change of condition (COC), assessment, vital signs, reporting, physician's orders [REDACTED]. 7. A wound Care Surgical Group was hired that will come to the facility on Fridays to assist with resident's wound treatments. 8. The facility has two designated wound treatment nurses for the week and weekend for the COVID area and two wound treatment nurses that will designated to cover the non-COVID area. 9. Resident 2's [DEVICE] was changed on 6/12/2020. 7. The Quality Assurance and Assessment ((QAA) team members working together concerns in a facility) will be communicated in a monthly basis for the next three months until the manner is considered resolve. 8. The Interdisciplinary Team ((IDT) group of healthcare providers residents from different fields who work together toward the same goal to provide the best care or outcome for a patient) will identify any items that need to be added to a resident's baseline care plan. 9. The CNE will track any trends or concerns regarding personalized baseline care plans. On 6/14/2020 at 1:27 p.m., during an interview with the CNE and the MDSN were notified the IJ was lifted, after the team verified the POA was followed and implemented observations, interviews and record reviews. Findings: a. A review of Resident 1's Face Sheet (Admission Record) indicated the facility first admitted the resident on 1/14/11 and was last readmitted on [DATE]. Resident 1's [DIAGNOSES REDACTED]. [MEDICAL CONDITION] (paralysis on one side of the body) affecting right dominant (most important) side of the body. A review of Resident 1's Minimum Data Set (MDS), a resident assessment and care-screening tool, dated 3/8/2020 indicated the resident was sometimes understood and sometimes understand others. The MDS indicated the resident was totally dependent requiring a two or more-person physical assist for bed mobility (how the resident moves to and from lying position, turning side to side, and positioning of body) and a one-person physical assist for personal hygiene. The MDS indicated Resident 1 was always incontinent of bowel and bladder (lack of voluntary control) and had limited range of motion on one side of upper extremities and impairment of bilateral (both) lower extremities. The MDS indicated Resident 1 did not have pressure ulcers upon admission but was at risk to develop them. A review of Resident 1's Braden Scale (scale for predicting pressure sores), dated 12/10/19 indicated Resident 1's score for pressure ulcers development was moderate risk with a total score of 13. The lower the number, the higher the risk for developing an acquired ulcer/injury, as follow: 19-23 = no risk; 15-18 = mild risk; 13-14 = moderate risk. A review of Resident 1's care plan titled, Skin Breakdown, with revised date of 3/15/15 indicated Resident 1 was at risk for skin break due to impaired sensation, limited mobility and history of pressure ulcer. The care plan goal Resident 1 not to show signs of skin breakdown. The staffs' interventions included to evaluate and monitor for any localized skin problems, such as dryness, redness, pustules (small blister or pimple on the skin containing pus) and inflammation. The staff to observe skin condition and report abnormalities to primary physician. A review of Resident 1's Change of Condition ((COC) decline or improvement in a resident's mental or physical functioning) dated 4/29/2020 and timed at 11:12 a.m. indicated the resident was assessed with [REDACTED]. The nurse's note indicated the physician was notified and no new orders given. A review of Resident 1's nurse's notes from 4/29/2020 through 5/1/2020 did not indicate a wound treatment what initiated to prevent further worsening of the world. A review of Resident 1's Skin Integrity Report, indicated the measurements for the resident's sacral wound as follow: On 5/2/2020 the measurements were 4 cm in length (L) by(x) 3.5 cm width (W) x 0.1 cm depth (D) with bloody drainage and no odor. On 5/8/2020 the measurements were 4.5 cm x 3.7 cm x 0.5 cm with heavy bloody drainage and no odor. On 5/15/2020 the measurements were 5.1 cm x 3.8 cm x 0.5 cm with heavy bloody serosanguineous drainage with odor. On 5/22/2020 the measurements were 5.2 cm x 4 cm x 0.7 cm with heavy bloody drainage with odor. On

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F 0686 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) 5/29/2020 the measurements were 5.3 cm x 4 cm x 0.6 cm with heavy bloody drainage with odor. A review of Resident 1's ADL Correction Form indicated on 5/13/2020, 5/17/2020, 5/20/2020, and 5/23/2020 the CNAs noted the sacral wound bad odor and worsen condition. The CNAs note indicated the facility's charge nurses were notified. A review of Licensed Progress notes, dated from 5/1/2020 through 5/29/2020 did not indicate Resident 1's primary physician was notified of sacral ulcer worsening with a bad odor and/or a wound physician consulted. A review of Resident 1's Laboratory results collected on 5/30/2020 and timed at 3 p.m. with a result report, dated 6/3/2020 and timed at 3:34 p.m. indicated Resident 1 had moderate growth of bacteria on the sacral area. A review of Resident 1's Nurse's notes dated 6/4/2020 and timed at 2:03 p.m. indicated Resident 1's primary physician ordered to transfer Resident 1 to the GACH for evaluation of the sacral wound infection. The note indicated Resident 1 was transported to the GACH on 6/4/2020 at 11:45 a.m. A review of Resident 1's Discharge Form, dated 6/4/2020 indicated to discharge resident to the general acute care hospital (GACH) for infected sacral wound. A review of Resident 1's GACHs ED note dated 6/4/2020 indicate Resident 1 was admitted for evaluation sacral ulcer and alter mental status. A review of the GACHs Consultation Note, dated 6/5/2020 and timed at 12:53 p.m., indicated Resident 1 had an infection related to an infected sacral ulcer. A review of Resident 1's GACH operative report dated 6/9/2020 and timed at 7:30 p.m., indicated a post-operative [DIAGNOSES REDACTED]. The report indicated a sharp excisional debridement (removal of damage tissue) with a Bovie (instrument used for electrosurgical dissection) was use to cut of skin, subcutaneous tissue, muscle, fascia (thin casing of connective tissue that surrounds and holds every organ), ligaments (flexible fibrous connective tissue which connects two bones or cartilages or holds together a joint) and bone. The report indicated much of the sacral bone had eroded (destroyed). A review of Resident 1's pathology (branch of medicine that deals with the laboratory examination of samples of body tissue) report, collected on 6/10/2020 with results received on 6/11/2020 indicated the resident had a [DIAGNOSES REDACTED]. On 6/8/2020 at 5:30 p.m., during a telephone interview, Licensed Vocational Nurse 1 (LVN 1) stated the facility did not have a treatment nurse for the month of May 2020 because the treatment nurse was sent to the COVID area. LVN 1 stated not being able to complete the daily wound treatments for the residents because not having enough time. LVN 1 stated notifying LVN 3 to assist with the treatments, but LVN 3 would sign as completed without doing the wound treatments. LVN 1 stated Resident 1's physician was not notified of the resident wounds. LVN 1 stated the CNE did not do anything when she was notified of the resident's wounds. On 6/10/2020 at 8:56 a.m., during a telephone interview, LVN 2 stated she did not have time to get to all the wound treatments. LVN 2 stated the facility did not have an assigned treatment nurse and the LVN's had to conduct their own medication pass and wound treatments for all residents. On 6/10/2020 at 9:23 a.m., during a telephone interview, Certified Nurse Assistant (CNA 1) stated the facility did not have assign treatment nurses. CNA 1 stated being forced to perform wound treatment for [REDACTED]. On 6/11/2020 at 10:45 a.m., during a concurrent interview and record review of the Licensed Progress notes, LVN 3 stated Resident 1 was sent out to the GACH a week ago for evaluation of sacral wound infection. LVN 3 stated Resident 1's physician was notified on 20 of the worsening of the wound and the bad odor coming from the wound. LVN 3 stated no documentation was done of the physician notification or wound assessments. On 6/11/2020 at 11:58 a.m., during an interview and review of Resident 1's clinical chart, Registered Nurse 1 (RN 1) stated first informing Resident 1's primary physician on 4/30/2020. RN 1 stated no orders for wound treatment were carried out until 5/2/2020, three (3) days after the wound was identified. RN 1 stated the wound consult ordered on [DATE] was not carried out. RN 1 stated it was the responsibility of the treatment nurse to assess and document the status of the wound. The RN 1 stated no documentation of Resident 1's wound assessment was done. On 6/11/2020 at 1:20 p.m., during an interview and review of Resident 1's record with the CNE and the MDSN, the MDSN stated Resident 1's Stage II sacral ulcer was identified on 4/29/2020 and physician orders [REDACTED]. The MDSN stated no wound treatments were done on 4/29/2020 through 5/1/2020. The MDSN stated no there was no wound assessments and or IDT done or found in Resident 1's clinical chart. The MDSN stated the RN 1 fail to enter the physician's orders [REDACTED]. On 6/12/2020 at 4:19 p.m., during a telephone interview, Resident 1's family member (FM 1) stated Resident 1 was admitted to the facility without wounds to her sacral area. FM 1 stated being informed by the GACHs upon Resident 1's admission of the severity of the sacral wound. FM 1 stated the facility did not made attempts to notify the family regarding the development of Resident 1's sacral ulcer. On 6/12/2020 at 7:10 p.m., during an interview, CNA 7 stated several charge nurses were made aware of Resident 1's wounds but nothing was done. CNA 7 stated all the Licensed Nurses in the facility were aware about Resident 1's sacral ulcer, but did not care. CNA 7 stated Resident 1's wound was black in color, with green drainage and bad odor. CNA 7 stated not being able to turn all residents every two (2) hours because of the workload. On 6/14/2020 at 12:30 p.m., during an interview, CNA 2 stated Resident 1's wound smelled as if it was rotten and had brown/red drainage. On 6/15/2020 at 3:15 p.m., during a telephone interview, Resident 1's FM 2 stated the facility neglected the resident and did not prevent the wound in her sacral area. FM 2 stated of not being made aware of Resident 1's wound by the facility. FM 2 stated Resident 1 would complain of back pain, but the facility would ignore her pain. FM 2 stated feeling bad the facility did not care for Resident 1. b. A review of Resident 3's Face Sheet (Admission Record) indicated the facility admitted the resident on 6/5/2020. Resident 3's [DIAGNOSES REDACTED]. A review of Resident 3's Braden Scale, dated 6/5/2020 indicated Resident 3's score for pressure sores development was moderate risk with a total score of 18. A review of Resident 3's care plan titled, Resident has Actual Skin Breakdown on Sacral Area, dated 6/6/2020. The goal was for the resident's sacral ulcer to decrease in size and heal. The staffs' interventions included to evaluate and monitor for any localized skin problems such as dryness, redness, pustules and inflammation, observe skin condition, care and report abnormalities to primary physician. During a review of Resident 3's Weekly Bath and Skin Report, dated 6/8/2020 indicated Resident 3 was noted with open areas on the bilateral forearms, right knee, right foot and sacral area. The report indicated the charge nurse was notified of the open body areas. A review of Resident 3's Licensed Progress notes, dated 6/5/2020 through 6/11/2020 did not indicate the physician was notified of Resident 3's opened skin areas and sacral wound. A review of Resident 3's Licensed Progress note, dated 6/5/2020 and timed at 7:10 p.m. indicated Resident 3 was admitted to the facility with a Stage III sacral wound. A review of Resident 3's Treatment Assessment Record (TAR) for the month of June 2020 did not indicate a sacral wound care treatment was initiated upon admission on 6/5/2020. A review of Resident 3's skin integrity report, dated 6/12/2020 indicated a sacral pressure wound Stage IV identified measuring 2.4 centimeters (cm (unit of measurement)) in length by 2.4 cm in width by 0.5 cm in depth. The skin integrity report indicated underlining in all directions of the wound measuring 1 cm and moderate serosanguineous (collection of body fluid and blood) drainage. On 6/11/2020 at 10 a.m., during an observation of Resident 3's wounds with LVN 2, LVN 2 stated Resident 3's sacral wound had not been treated because she was passing medications. LVN 2 stated wound care treatments are completed from 6 am to 8 am. On 6/11/2020 at 4:20 p.m., during an interview and review or Resident 3's care plans and TARs, the RN 1 indicated being aware Resident 3 was admitted with s sacral wound but fail to initiate a care plan for interventions to prevent the wound from worsening. RN 1 also stated she did not enter the wound treatment orders because, I was too busy and did not have time. RN 1 stated she forgot to do treatment orders for Resident 3. c. A review of Resident 4's Face Sheet (Admission Record) indicated the facility first admitted the resident on 2/20/2020 and was last readmitted on [DATE]. Resident 4's [DIAGNOSES REDACTED]. A review of Resident 4's MDS dated [DATE] indicated the resident sometimes understood and understand others. The MDS indicated Resident 4 required extensive assist of a one-person physical assist for bed mobility. The MDS indicated Resident 4 was always incontinent of bowel and had impairment of bilateral lower extremities. The MDS indicated Resident 4 had two (2) pressure ulcers. A review of Resident 4's Braden Scale, dated 4/7/2020 indicated Resident 4's score for pressure sores development was moderate risk with a total score of 16. A review of Resident 4's skin assessment, dated 4/7/2020 indicated the resident did not have sacrum wounds. A review of Resident 4's care plans did not indicate a plan of care for the sacral ulcer was created on 5/11/2020 when the wound was identified. A review of the Licensed Progress note dated 5/11/2020 and timed at 1:07 p.m. indicated a skin wound was identified. At 10:36 p.m. on 5/11/2020 a note indicated a COC was initiated for Resident 4's left buttock Stage II and lower back skin wound. A review of Resident 4's physician's telephone order, dated 5/12/2020 indicated to turn and reposition Resident 4 every two (2) hours and perform wound care evaluation. A review of Resident 4's Licensed Progress note, dated 5/19/2020 and timed at 5:29 p.m. indicated Resident 4 was noted with a sacral ulcer measuring 10 cm in L x 8 cm in W and no depth. On 6/13/2020 at 10:40 a.m., during a telephone interview, FM 3 stated Resident 4 was transfer to a GACH for evaluation of wounds. FM 3 stated the facility fail to notify them of Resident 4's sacral wound. FM 3 stated Resident 4 did not have any wounds on the sacral area upon admission to the facility. On 6/13/2020 at 3:30 p.m., during an interview, LVN 8 stated there was no treatment done for Resident 4's sacral ulcer. LVN 8 stated Resident 4's sacrum wound developed in the facility. On 6/14/2020 at 1 p.m., during an interview and review of Residents 1, 3 and 4 clinical records (care plans, TARs, nurses notes, COC, physician orders, ADL sheets) indicated the CNE stated and confirmed the facility's staff did not follow the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555004	A. BUILDING _____ B. WING _____	**07/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PLAYA DEL REY CENTER	**7716 MANCHESTER AVENUE PLAYA DEL REY, CA 90293**

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F 0686 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 4) policy for wounds and the staff was responsible to assess, document, and carried out orders for residents. The CNE stated Residents 1 and 4 developed sacral wounds that worsen in the facility and Resident 3's sacral wound worsens in the facility. The CNE stated the staff fail to notify the resident's physician, create and update care plan, prevent development/worsening of sacral wounds and provide treatment as order by the primary physician. The CNE stated she was not made aware of the wounds because she was focus on the COVID (virus) residents. A review of the facility's policy and procedures (P/P) titled, Skin Integrity Management, revised 1/31/2020 indicated the purpose of the facility was to provide safe and effective care to prevent the occurrence of pressure ulcers, manage treatment, and promotes healing of all wounds. The P/P indicated the standard of practice was for staff to review pre-admission information to plan patient's needs prior to admission, identify patient's skin integrity status and need for prevention interventions or treatments modalities through review, perform skin inspection on admission/re-admission and weekly. Perform wound observation and measurements upon initial identification, weekly and upon decline. The P/P indicated to notify the physician to obtain orders and notify resident's representative/family and document daily monitoring.
F 0693 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents received the necessary care and services for one of three sampled residents (Residents 2) who had a gastrostomy tube ([DEVICE]) a tube surgically inserted through the abdomen into stomach for fluid and medication nutrition). Resident 2's [DEVICE] was discolored black and had a look of being unsantitary and the Resident 2 expressed This deficient practice resulted in Resident 2 feeling neglected because of the appearance of the [DEVICE]. Findings: A review of Resident 2's Face Sheet (Admission Record) indicated the facility first admitted the resident on 12/20/18. Resident 2's [DIAGNOSES REDACTED]. A review of Resident 2's Minimum Data Set (MDS), a resident assessment and care-screening tool, dated 3/29/2020 indicated the resident was usually able to understand and be understood by others. The MDS indicated Resident 2 required an extensive assistance of a one-person physical assist for bed mobility (how the resident moves to and from lying position, turning side to side, and positioning of body). A review of Resident 2's care plan titled, Gastrostomy tube, dated 1/10/2020 did not indicate the intervention the facility's staff would perform to maintain the resident's [DEVICE]. A review of Licensed Vocational Nurse 3's (LVN 3) written declaration, dated 6/11/2020 and timed at 10:45 a.m., indicated Resident 2's [DEVICE] has been black in color for over a year. Resident 2's primary physician was made aware of the discolored [DEVICE]. On 6/11/2020 at 11:15 a.m., during an observation of Resident 2's [DEVICE] and an interview, the Center Nurse Executive (CNE) and the Minimum Data Set Nurse (MDSN) stated not knowing why Resident 2's [DEVICE]'s tubing was black. Resident 2 stated, It does not look good. On 6/11/2020 at 11:30 a.m., during an interview, Resident 2's physician (Physician 1) stated he was made aware of Resident 2's [DEVICE] being black and did not consider the need to change the [DEVICE]. On 6/13/2020 at 11:35 a.m. during an observation and interview and in the presence of the CNE, Resident 2 stated after the [DEVICE] was replaced she felt happy of her new [DEVICE] and stated, I love it, I am happy, it is not yucky anymore. Resident 2 was observed smiling and saying, Thank you. On 6/14/2020 at 1 p.m., during an interview and review of Resident 2's clinical records (care plans, TARs, nurses notes, COC, physician orders, ADL sheets) indicated the CNE stated and confirm the facility's staff did not follow the policy for wounds and the staff was responsible to assess, document, and carried out orders for residents.