STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055776	A. BUILDING _____ B. WING _____	**03/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTVIEW HEALTHCARE CENTER	**12225 SHALE RIDGE LANE AUBURN, CA 95602**

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 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the comprehensive care plan was reviewed and revised as changes occurred in the development of a pressure ulcer for 1 of 3 sampled residents (Resident 1). This failure had the potential to result in not providing adequate care and treatment for [REDACTED]. Findings: Resident 1 was admitted to the facility in October 2016 with [DIAGNOSES REDACTED]. An Admission Skin assessment dated [DATE] at 17:52 (5:52 p.m.) had no documented evidence of any pressure ulcers or wounds on Resident 1's skin on admission to the facility. Review of a facility document dated, [DATE] (on admission for Resident 1) titled, Observation Summary List indicated, Braden Scale Total (A skin assessment tool) score of 15, at risk. (Braden Scale score of 0-15, 15 being high risk for skin breakdown). A review of a Care Plan dated, 10/7/16 indicated, Skin Care Plan: At risk for altered skin integrity.Will reduce the risk for impaired skin integrity. Approach Start Date: 10/7/16. Monitor for any signs of skin breakdown (sore, tender, red, or broken areas). Review of a facility document dated, [DATE] and titled, Observation Summary List indicated, Skin-Pressure Ulcer Report: Date Occurred: [DATE].Short Description: Unstagable R (right) heel. There was no documented evidence in the clinical record of a comprehensive care plan being revised as needed for Resident 1 to prevent or minimize pressure ulcer development. Review of a facility document dated [DATE] and titled, Nursing to MD/NP (Medical Doctor/Nurse Practitioner) Communication Form, indicated, Unstagable ulcer of R (right) heel noted today. Physician/NP response or order: (Brand name) Boot. There was no documented evidence that the care plan was revised to address interventions for the prevention of further skin breakdown for Resident 1's right foot wound. A physician's orders [REDACTED].boot to RLE (right lower extremity) at all times. Check placement at all times. Every shift: NOC (night shift), AM (morning shift), PM (evening shift). Remove boot from R (right) leg and assess skin, then replace boot Q (every) shift. Every shift: NOC, AM, PM. There was no documented evidence in the clinical record these orders were carried out as written, no progress notes to indicate the assessments were completed by staff, and no documented comprehensive care plan revision to reflect these orders from the physician. Review of the Minimum Data Set (MDS- an assessment tool) dated 10/13/16 indicated, Resident 1 required two people to assist with activities of daily living, bathing, dressing, and eating. Resident 1 was able to self propel in a wheelchair for mobility using the left leg only. The Brief Interview for Mental Status (BI[CONDITION]) indicated a score of 10, (BI[CONDITION] score of 8-12 indicated moderate cognitive impairment). Resident 1 was alert with difficulty speaking and was confused at times. Resident 1's family assisted with decision-making. On admission, Resident 1's right hip surgical site wound was documented as healing without infection. Review of a physician's orders [REDACTED]. There was no documented evidence in the clinical record these orders were followed by staff. There was no documented evidence of a revised comprehensive care plan addressing the physician's orders [REDACTED].Right leg in (boot).Right heel superficial wound 2.5 cm (centimeter-measurement) then 1 cm x 2 cm wound just above overlying Achilles tendon (back of the ankle area). Both appear to be located where skin is rubbing on (boot). There was no documented evidence in the clinical record of a comprehensive care plan revision or implementation for Resident 1's right heel or right ankle wounds. A Progress Note dated 11/5/16 indicated, Wound Review: Unstagable PU (pressure ulcer) of the right heel, Wound Size: (L x W x D) (Length x Width x Depth): 3.5 x 3 x not measurable cm (centimeter measurement).Unstageable of the right posterior ankle: Wound Size: 2.5 x 1.5 x not measurable cm.Plan/Action: Continue treatment and monitoring as ordered. Review of an Interdisciplinary Team (IDT) Note, dated 11/6/16 indicated, IDT Wound Review: .Boot was an intervention for pressure relief.IDT is exploring alternative surfaces in order to remove boot which is contributing to ulcerations. There was no documented evidence of a comprehensive care plan revision updated to prevent further skin breakdown. A Director of Nursing (DON) Progress Note dated 11/8/16 indicated, .MD aware of wound created by boot and is ok with continuing the use of boot. There was no documented evidence of updates or interventions to Resident 1's care plan to prevent further skin breakdown. An interview was conducted on 1/13/17 at 10:49 a.m. with the Assistant Director of Nursing (ADON). The ADON stated the boot was ordered for Resident 1 to protect the right heel. The ADON further stated, the right heel was the area of skin breakdown with the back of the right ankle. The ADON was not aware of a care plan updated for wound care for Resident 1. The ADON confirmed these documents (care plans) were not available in the clinical record. Review of a facility policy, revised October 2010, and titled, Wound Care indicated, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Review the resident's care plan to assess for any special needs of the resident. The following information should be recorded in the resident's medical record: 1. The type of wound care given. 2. The date and time the wound care was given. 3. The position in which the resident was placed. 4. The name and title of the individual performing the wound care. 5. Any change in the resident's condition. 6. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care and services to meet professional standards of practice for 1 of 3 sampled residents (Resident 1) when the facility failed to follow physician orders. This failure had the potential to result in not providing adequate care and treatment for [REDACTED]. Findings: Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. An Admission Skin assessment dated [DATE] at 17:52 (5:52 p.m.) had no documented evidence of any pressure ulcers on admission to the facility. Review of a facility document dated, [DATE] (on admission for Resident 1) titled, Observation Summary List indicated, Braden Scale Total (A skin assessment tool) score of 15, at risk. (Braden Scale score of 15 being high risk for skin breakdown). A review of a Care Plan dated, 10/7/16 indicated, Skin Care Plan: At risk for altered skin integrity.Will reduce the risk for impaired skin integrity.Approach Start Date: 10/7/16. Monitor for any signs of skin breakdown (sore, tender, red, or broken areas). Review of a facility document dated, [DATE] and titled, Observation Summary List indicated, Skin-Pressure Ulcer Report: Date Occurred: [DATE].Short Description: Unstagable R (right) heel. (The skin breakdown developed 6 days after admission to the facility). Review of a facility document dated [DATE] and titled, Nursing to MD/NP (Medical Doctor/Nurse Practitioner) Communication Form indicated, Unstagable ulcer of R (right) heel noted today. Physician/NP response or order: (Brand name) Boot. A physician's orders [REDACTED].boot to RLE (right lower extremity) at all times. Check placement at all times. Every shift: NOC (night shift), AM (morning shift), PM (evening shift). Remove boot from R (right) leg and assess skin, then replace boot Q (every) shift. Every shift: NOC, AM, PM. There was no documented evidence in the clinical record the orders were carried out as written. Review of the Minimum Data Set (MDS- an assessment tool) dated 10/13/16 indicated, Resident 1 required two people to assist with activities of daily living, bathing, dressing, and eating. Resident 1 was able to self propel in a wheelchair for mobility using the left leg only. The Brief Interview for Mental Status (BI[CONDITION])

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 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) indicated a score of 10, (BI[CONDITION] scoring a score of 8-12 indicated moderate cognitive impairment). Resident 1 was alert with difficulty speaking and was confused at times. Resident 1's family assisted with decision-making. On admission, Resident 1's right hip surgical site wound was documented as healing without infection. Review of a physician's orders [REDACTED]. There was no documented evidence in the clinical record these orders were followed by staff. There was no documented evidence the wound or the boot were assessed every shift as ordered. A Nurse Practitioner (NP) Progress Note, dated 10/26/16 (13 days after admission to the facility) indicated, Encounter date: 10/26/16.Right leg in (boot).Right heel superficial wound 2.5 cm (centimeter-unit of measure) then 1 cm x 2 cm wound just above overlying Achilles tendon (back of the ankle area). Both appear to be located where skin is rubbing on (boot). A Progress Note dated 11/5/16 indicated, Wound Review: Unstagable PU (pressure ulcer) of the right heel, Wound Size: (L x W x D) (Length x Width x Depth): 3.5 x 3 x not measurable cm (centimeter measurement).Unstageable of the right posterior ankle: Wound Size: 2.5 x 1.5 x not measurable cm.Plan/Action: Continue treatment and monitoring as ordered. There was no documentation in the clinical record staff were checking Resident 1's boot on the right foot every shift, and there was no documented evidence of a skin assessment to the right heel or right ankle when taking the boot off every shift as ordered. Review of an Interdisciplinary Team (IDT) Note, dated 11/6/16 (One month after admission to the facility) indicated, IDT Wound Review: .Boot was an intervention for pressure relief.IDT is exploring alternative surfaces in order to remove boot which is contributing to ulcerations. A Director of Nursing (DON) Progress Note dated 11/8/16 indicated, .MD aware of wound created by boot and is ok with continuing the use of boot. A Nurse's Progress Note, dated 1/8/17 indicated, Pt (Patient/Resident 1) in bed this am, sluggish, dyphoretic (sic), and irritable. Pt's vs (vital signs) taken with noted rise in temp of 102 degrees orally.on call MD notified of pt's change and gave T.O. (telephone order) to send for eval and tx (evaluation and treat) as indicated.report called and given to (General Acute Care Hospital-GACH). An interview was conducted on 1/13/17 at 10:49 a.m. with the Assistant Director of Nursing (ADON). The ADON stated the boot was ordered for Resident 1 to protect the right heel. The ADON further stated, the right heel was the area of skin breakdown with the back of the right ankle. The ADON was not aware of a care plan updated for wound care for Resident 1. The ADON confirmed these documents (care plans) were not available in the clinical record. Review of a facility policy, revised October 2010, and titled Wound Care indicated, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Review the resident's care plan to assess for any special needs of the resident. The following information should be recorded in the resident's medical record: 1. The type of wound care given. 2. The date and time the wound care was given. 3. The position in which the resident was placed. 4. The name and title of the individual performing the wound care. 5. Any change in the resident's condition. 6. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound. 7. How the resident tolerated the procedure. 8. Any problems or complaints made by the resident related to the procedure. 9. If the resident refused the treatment and the reason(s) why. 10. The signature and title of the person recording the data. Reporting: 1. Notify the supervisor if the resident refuses the wound care. 2. Report other information in accordance with facility policy and professional standards of practice.