STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555435	A. BUILDING _____ B. WING _____	09/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RECHE CANYON REGIONAL REHAB CENTER	**1350 RECHE CANYON RD COLTON, CA 92324**

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 observation, interview, and record review, the facility failed to ensure professional standards of practice were followed to promote healing, prevent infection and prevent the worsening of a pressure ulcer from occurring for one of three resident's (Resident 1) when staff did not follow treatment and services per physician's orders. This failure resulted in Resident 1, who was admitted with a stage 1 (reddened non- blanchable area over bony prominence) pressure ulcer on her coccyx (tailbone) to have the wound progress to involve to a deeper level of tissue involvement requiring a [MEDICATION NAME] agent (removes dead skin), becoming infected and affecting her health and well-being. Findings: A review of Resident 1's face sheet (includes demographic information) indicated she was admitted to the facility originally on November 15, 2019, then readmitted on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 1's admission progress notes dated December 9, 2019, indicated the following: History of Presenting Illness (HPI) - discharged from (Name of Hospital) on November 15, 2019, for treatment of [REDACTED]. admitted to (Name of Facility) for rehabilitation, November 15, 2019 through November 28, 2019 and did well. fell at home and readmitted for pain management. She wanted [MEDICATION NAME] (a highly addictive pain medication for moderate to severe pain management). PLAN: Admit for skilled care Physical Therapy/Occupational Therapy (PT/OT) after fall at home resulted in left ankle fracture which included fracture through fourth metatarsals. 60 minutes of which was greater than 50% spend in counseling/coordination of care. Rehabilitation, pain management, discharge planning. A review of Resident 1's Admission screening notes dated December 8, 2019, indicated the nurse had documented the following: Resident 1 has fracture on left lower leg and cast on. Right foot is [MEDICAL CONDITION] (swollen with excessive amount of fluid). P/U (pressure ulcer) at coccyx (Stage 1) pressure ulcer is becoming worse. A review of Resident 1's order summary report dated active orders dated July 14, 2020 indicated the following: 1. None weight bearing to left lower extremity every shift dated December 8, 2019. 2. Cast care to left lower extremity: Monitor skin around cast area for sign and symptoms of infection dated December 8, 2019. 3. Weight bear as tolerated (WBAT) with cane walker in place dated December 19, 2019. 4. Air loss mattress for prevention/decubitus management every shift dated December 11, 2019. A review of Resident 1's physician's order dated December 8, 2019 at 5:30 PM, indicated the following: Body site: Coccyx (tailbone area) cleanse area with normal saline, pat dry, cover with a foam dressing every day shift for pressure injury for 21 days. A review of Resident 1's physician's order dated December 8, 2019 at 5:30 PM, indicated the following: Body site: Right heel cleanse area with normal saline, pat dry, cover with a foam dressing every-day shift 3 days for redness/protection for 21 days. A review of Resident 1's physician's order dated December 11, 2019, indicated the following: No Foam Dressing on her Sacrum (area just above tailbone)-To wound reuse Non Blanchable stage 1 (redness of a localized area over a bony prominence) 2. Every two-hour positioning 3. Triad Cream (wound dressing for local management of pressure ulcers) to sacrum stage 1. A review of Resident 1's physician's order dated December 26, 2019, indicated the following: Do not use Foam Dressing on coccyx. Resident wound getting worse. 3. Wound care instructions-coccyx-cleanse with Dakins (used to prevent and treat skin and tissue infections that result from pressure sores)- apply Santyl ([MEDICATION NAME] agent that removes dead skin so wound can heal) cover with calcium alginate's (used in treatment to absorb drainage, clean wound bed and promote healing in wounds that penetrate through deeper layers of skin) dry dressing. A review of Resident 1's, Nursing Home to Hospital Transfer Form, dated January 1, 2020, indicated reason for transfer-other-per family requested related to (r/t) wound. Under the areas to describe Skin/Wound Care it was left blank. During an interview on March 27, 2020 at 1:00 PM, with the Director of Nurses (DON), the DON stated Resident 1 was transferred out to (Name of the Hospital) due to her daughter's request on January 1, 2020, for an evaluation on her pressure ulcers. The DON stated Resident 1's daughter was concerned about Resident 1's pressure ulcers (P/U- refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence) I believe there was a problem with not following the physician's orders for treatment for [REDACTED]. Resident 1 did decline to move and get out of bed frequently and would decline staff to turn her in bed. The DON stated, My nurses should be following physician orders for all their residents to provide the highest practicable level of care to them. The DON further stated, If they are not following physician orders, that could affect Resident's health and well-being. During a follow up interview on March 27, 2020 at 1:50 PM, with the DON, the DON stated it was reported to him that there was an issue with the treatment nurses not following the physician's orders for wound care for Resident 1. The DON stated he believes it mainly occurred on the weekends. The DON confirmed staff were not following the treatment orders written by the physician for Resident 1. During an interview on May 5, 2020, at 11:20 AM, with the Licensed Vocational Nurse/Treatment Nurse (LVN/TX), confirmed providing wound care for Resident 1. LVN/TX stated the process for providing wound care for a resident was, You need to review physician orders, possible medicate the resident for pain, prepare your equipment, talk to the resident about the procedure, and wash your hands prior to starting. When you are finished you need to document. Resident should have their skin monitored, repositioned frequently and care planned. When asked about a foam dressing order for Resident 1 LVN/TX stated, I believe it was only for a few days. During an interview with the Assistant Director of Nurses/ Infection Preventions Nurse (ADON/IP), the ADON/IP stated, Residents admitted from (Name of Hospital) come with admission orders [REDACTED]. If it was a weekend, she would call the physician and review them and ask if there are any changes. If it is a weekday, the physicians at the facility will review all orders and make any changes to the orders. A review of Resident 1's Nutritional Risk assessment dated [DATE], indicated the following: Labs (blood work done for diagnostic purposes) reviewed with physician. Recommendations-At risk for weight loss related to pressure skin injuries. Recommended vitamin's for daily wound healing. 2. Boost glucose drink to control blood sugar. 3. Vitamin C (a vitamin). A review of Resident 1's weekly wound evaluation dated December 23, 2019, the nurse had documented the following: Site coccyx-type pressure (2x2 Stage 2) and becoming worse. A review of Resident 1's weekly wound evaluation dated December 30, 2019, the nurse had documented the following: Site coccyx-type pressure length 2.5 centimeter (cm Unit of measure)-width 2.0cm-depth 0.5cm-stage 2 (Stage 2 pressure ulcer is an abrasion, blister or crater). Response to treatment/comments-wound orders changed to help wound response better. Is resident 1 experiencing pain related to wound? 'No.' Physician notified of changes 'Yes!' Date December 31, 2019. Notified responsible party (daughter) on December 31, 2019. A review of Resident 1's Care Plan for pressure injury or potential for pressure injury development and/or wound worsening/delayed healing related to disease process was initiated on December 12, 2019 (four days after a wound had been identified). The care plan indicated Resident 1, Needs extensive assistance to turn/reposition at least every 2 hours or more often as requested. A review of Resident 1's, Documentation Survey Report, for skin monitoring, dated December 8, 2019, through December 31, 2019, indicated several blanks were found on the form which would have indicated the status of the wound to her coccyx area or if new wounds had developed during that time frame. A review of Resident 1's, Documentation Survey Report, for monitoring turn/reposition dated December 8, 2019, through December 31, 2019, indicated several blanks were found on the form which would have indicated whether Resident 1 was turned and repositioned every two hours as ordered by the physician during that time frame. During a concurrent interview and review of Resident 1's Documentation Survey Report on July 14, 2020, with the DON,

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) the DON confirmed staff did not follow physician's orders for turning and repositioning, and skin monitoring every 2-hours. A review of the facility's policy and procedure titled, Wound Care, revised October 2016, indicated .The purpose of this procedure is to provide guidelines for the care of wounds to promote healing's. Verify that there is a physician's order for this procedure. Review the Resident's care plan to assess for any special needs of the resident. Place call light within easy reach of the resident. Document wound care provided. If the resident refused the treatment and reason why. A Job Description and Performance Standards titled, Treatment Nurse, indicated . The purpose of this position is to follow facilities policies and procedures to implement treatment orders; to assess resident treatment needs and take appropriate action and to participate in supervision of care provided to residents. Administer treatments according to the physician's order and accurately record treatments administered weekly progress notes.