DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555103	A. BUILDING _____ B. WING _____	C 06/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRENCH PARK CARE CENTER	600 E WASHINGTON AVENUE SANTA ANA, CA 92701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an ABBREVIATED survey for COMPLAINT No: CA00845398. Inspection was limited to the specific COMPLAINT investigated and did not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Surveyor 39199, HFEN. FOR COMPLAINT NO. CA00845398: THE DEPARTMENT WAS UNABLE TO SUBSTANTIATE THE COMPLAINT ALLEGATION(S) AND FOUND NO VIOLATION OF THE REGULATIONS. HOWEVER, DURING THE INVESTIGATION, THE DEPARTMENT DETERMINED THERE WAS A VIOLATION OF THE REGULATIONS UNRELATED TO THE COMPLAINT ALLEGATION(S). FINDINGS WERE CITED AT F686 FOR RESIDENT 1. GLOSSARY OF ABBREVIATIONS & BRIEF DEFINITIONS: DON - Director of Nursing Ischial tuberosity - a large round protrusion at the inferoposterior aspect of the ischium, also known as the sitting bone as this is where the weight of the body is held when seated P&P - Policy and Procedure	F 000	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider to the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of the Health and Safety Code 1280 and 42 C.R.F. 405.1907. F686 1. The corrective action(s) accomplished for the residents found to have been affected by the deficient practice: Resident 1 who was affected by this deficient practice is no longer a resident at the facility. On 6/30/2023, Director of Nursing (DON) In-serviced all Licensed Nurses about the facility's policy and procedure for skin assessment and evaluation. The DON focus on initial skin assessment on admission and weekly skin evaluation. The DON discussed the importance of accurately documenting any skin issues and providing accurate description, including but not limited to wound measurement. The DON explained that accurately describing any skin issue will help monitor the progression of the wound and to develop proper treatment plan. On 6/27/2023, the Administrator and DON provided 1:1 education to the nurse who did the initial skin assessment on Resident 1. The nurse understand the importance of accurately documenting the measurement of any skin issue in particular pressure ulcer, and any other description to monitor the progression of the wound and to develop proper treatment plan.	7/3/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	07/03/2023

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.

39199 POC accepted 7/5/23

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F 000	Continued From page 1 Stage 3 pressure ulcer - full thickness tissue loss; subcutaneous fat may be visible but bone, tendon or muscle are not exposed; slough may be present but does not obscure the depth of tissue loss; may include undermining and tunneling (damage to tissue beneath the skin surrounding the pressure ulcer). Unstageable pressure ulcer - full thickness tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar.	F 000	2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. On 6/28/2023, the DON and Medical records randomly checked 10 residents' chart admitted in the last 2 months. and found no other resident affected by this deficient practice. On 6/30/2023, the Unit Managers and Treatment Nurses did a skin sweep on all residents to identify any potential skin issue and found no resident with no skin issue.	7/3/2023
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services were provided to prevent the development or worsening of pressure ulcers for one of two sampled residents (Resident 1).	F 686	3. Measures that will be put into place or systematic change the facility will make to ensure that the deficient practice does not recur: The Admitting nurse or a designated Licensed Nurse will do skin assessment on all newly admitted resident and readmitted resident. The treatment nurse or Unit Manager will do skin re-evaluation the following day to confirmed and discussed with IDT during clinical meeting. Weekly IDT wound meeting is done to make sure progressions of any skin issue is being monitored and developed proper treatment plan. 4. Facility plans to monitor effectiveness of the corrective actions and sustain compliance; Integrate QA Process: Medical Records will audit all skin evaluation on all newly and readmitted resident. All findings will be reported to the DON on the daily basis to make sure skin evaluation was done according to facility's policy and procedure. The plan of correction will be presented at the next Quality Assurance (QA&A) committee meetings on 7/12/2023 and ongoing findings will be reported to QAPI/QAA monthly meetings for 3 months.	

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F 686	Continued From page 2 * The facility failed to obtain and document the measurements and other wound descriptions for Resident 1's pressure ulcers. This failure had the potential to result in the inability to monitor the progression of Resident 1's pressure ulcers. Findings: Review of the facility's P&P titled Skin Assessment revised 12/19/22 showed it is the policy to perform a full body skin assessment as part of the facility's systematic approach to pressure injury prevention and management. A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, and weekly thereafter, and after a change of condition or after any newly identified pressure injury. Documentation of the skin assessment will include ...the description of the wound (measurements, color, type of tissue in the wound bed, drainage, odor, pain) and other information as indicated or appropriate. Medical record review for Resident 1 was initiated on 6/14/23. Resident 1 was admitted to the facility on 6/6/23. Review of Resident 1's Skin Only Evaluation dated 6/6/23, showed the following: - Skin Issues #2 and #3 were both identified as unstageable pressure ulcers to the buttocks/ischial tuberosity area but failed to identify or distinguish the location (left versus right), no measurements were obtained and documented upon admission for either wound, and no description of the wound bed, wound exudate, peri wound condition, dressing saturation, or tissue was documented.	F 686		

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F 686	Continued From page 3 - Unstageable pressure ulcers were identified at Resident 1's sacrococcyx area (Skin Issue #4) and rectum (Skin Issue #5), and a Stage 3 pressure ulcer around Resident 1's tracheostomy site (Skin Issue #7). However, no measurements and other wound assessments (wound bed, exudate, peri wound condition, dressing saturation, wound odor, tunneling, undermining, and tissue description) were obtained and documented for these pressure ulcer sites. Further review of the resident's medical record showed measurements and a thorough assessment of Resident 1's pressure ulcer sites was not performed until 6/9/23, three days after Resident 1 was admitted to the facility. On 6/14/23 at 1208 hours, an interview and concurrent medical record review was conducted with the DON who verified the above findings. The DON verified thorough skin assessments were required upon admission and weekly thereafter to monitor the progress of the resident's pressure ulcers. The DON was unable to determine if Resident 1's pressure ulcers had worsened due to the incomplete baseline or admission skin assessments.	F 686		