STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555844	A. BUILDING _____ B. WING _____	C 10/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOVATO HEALTHCARE CENTER	1565 HILL ROAD NOVATO, CA 94947

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an Investigation of a Complaint: CA00782334. The inspection was limited to the specific Complaint Investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Surveyor #38335, Health Facilities Evaluator Nurse. Regulatory deficiencies were issued for Complaint CA00782334.	F 000		
F 686 SS=E	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 and record review, the facility failed to ensure a deep tissue injury (DTI, an injury to the soft tissue under the skin due to pressure and is usually over boney	F 686		10/25/23

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Santa Rosa D.O.

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

Jason H | Administrator | 11/1/2023

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.

11-6-23 POC accepted - Administrator

#38335

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F 686	Continued From page 1	F 686		

prominence)for one resident (Resident 2), received care and treatment to promote healing and prevent worsening in accordance with professional standards of practice, when the facility failed to document wound care interventions in the medical record and care plan.

This failure potentially worsened the resident ' s pressure ulcer and decline in the resident ' s quality of life.

Findings:

Resident 2 was an eighty-five-year-old admitted to the facility in early 2022, for post-surgical (relating to, or occurring in the period following surgery) orthopedic aftercare and physical rehabilitation. Upon admission, Resident 2 was assessed for multiple skin issues (e.g., surgical wounds, skin tears, pressure injuries (Pressure injuries are sores (ulcers) that happen on areas of the skin that are under pressure) and mobility issues related to lack of coordination and unsteadiness on feet.

During a medical record review of Resident 2's initial skin assessment evaluation, dated 3/15/22, the initial skin assessment indicated the resident was admitted with multiple skin integrity (skin health - A skin integrity issue might mean the skin is damaged, vulnerable to injury or unable to heal normally) problems including open lesions and skin tears on his upper extremities (right and left arms, mid back, and back of neck). Additionally, a deep tissue pressure injury (DTPI), depth unknown, was identified to the mid back-left side, length of 3 cm (centimeters-a metric unit of length) x (by) width 3 cm, depth undetermined. The skin assessment further indicated a surgical

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F 686	Continued From page 2 wound, located on the back of the neck, measured 11 cm with 11 staples. Skin abnormalities (e.g., Deep tissue pressure injury, suspect deep tissue injury, surgical wound, open lesions, and discoloration) were identified, without clinical suggestions for skin care interventions on the skin assessment evaluation. During a medical record review of a skin assessment evaluation dated 3/18/22, the skin assessment indicated a blister (a small bubble on the skin filled with serum/fluid and caused by friction, burning, or other skin damage) to the left upper buttock had no exudate (fluid produced by the wound), that measured 0.8 cm length x 0.8 cm width. The skin assessment indicated skin conditions continue to be identified and assessed without clinical suggestions for skin care interventions on the skin assessment evaluation. During a medical record review of a skin assessment evaluation, dated 3/25/22, the skin assessment indicated a pressure ulcer injury (suspect deep tissue injury-depth unknown) identified to the sacrum and measured 8 cm length x 8 cm width, no exudate (fluid that leaks out of blood vessels into nearby tissues or may ooze from cuts or from areas of infection or inflammation) was observed. No clinical suggestions for skin care interventions to the sacrum (a triangular bone in the lower back formed from fused vertebrae and situated between the two hipbones of the pelvis) were listed on the skin evaluation assessment. During a review of Resident 2 ' s Care Plan, the Care Plan, dated 4/4/22, did not specify skin care interventions to prevent worsening skin conditions for Resident 2.	F 686		

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F 686	Continued From page 3 A review of Resident 2's medical record progress notes did not show an Interdisciplinary Care Meeting (IDT) was held that included Resident 2 and/or his family to discuss and plan the resident's wound care needs. During an interview on 5/12/22, at 11:30 a.m., with Licensed Staff-A, Licensed Staff-A indicated he was not a certified wound care nurse and was recently hired into the position, without previous wound care experience. When asked if he knew Resident 2 and if he took care of Resident 2 during his admission, Licensed Staff-A stated he did not know Resident 2 or about his wound care. When asked to review the wound care binder he indicated there was no wound care binder. When asked how he knew of residents ' wound care needs, he stated he followed the wound care physician when he was in the facility on Fridays. When the Department requested to review the wound care physician's notes, Licensed Staff-A stated the physician ' s notes were in the wound care physician's computer to which he did not have access. During an interview on 10/13/23, at 11:30 a.m., with Licensed Staff-B, Licensed Staff-B stated she had been the wound care nurse for about 4 months. When questioning Licensed Staff-B about her responsibilities as the wound care nurse she stated she had provided wound care to the residents and did wound care rounds with a Certified Nursing Assistant (CNA) Monday through Thursday. Licensed Staff-B stated she was currently re-assessing all residents with skin conditions and documenting any changes to wound care on a change of condition form and on the treatment record (TAR) in Point-Click-Care	F 686		

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F 686	Continued From page 4 (PCC) the electronic medical record. When asked If there was a wound care committee Licensed Staff-B stated "No," but that she would notify the charge nurse with any wound care updates and notified the wound care physician. Licensed Staff-B stated there was a new wound care physician at the facility for 3-weeks and she met with him every Friday for wound care rounds and followed the orders in PCC provided by the wound physician. When asked to review the wound care binder Licensed Staff-B stated, she did not have one and the wound care physician had his own computer system for documentation of wound care. She stated during wound care rounds with the physician she took notes and entered the notes into the weekly progress notes in PCC. When asked how she knew if a wound was improving or getting worse, Licensed Staff-B stated the wound care physician would document any changes on a report and give her a copy. Licensed Staff-B entered the report along with physician orders in PCC. Licensed Staff-B was asked who provided wound care when she was not at the facility. Licensed Staff-B stated the nursing staff would provide the resident ' s wound care when she was not there. A copy of the wound care policy and procedures was requested. During an interview with the Wound Care Physician on 4/18/23 at 12:50 p.m., the Wound Care Physician was asked the natural progression of a Deep Tissue Injury (DTI), that was unstageable. He stated an unstageable wound means there is tissue loss but there was a covering of slough or eschar (a yellow cheesy covering over the tissue, or a black leathery covering over the tissue). All wounds were treated, depending on the type of wound and	F 686		

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F 686	Continued From page 5 consistency of the treatment will determine if the wound heals or progresses. The Wound Care Physician also stated, the type of treatment for an unstageable wound would require, for example, wet to dry dressings, turning the patient every 2-hours, and nutritional assessments with an increase in calorie intake. During a review of a facility policy and procedure titled "Pressure Injury and Skin Integrity Treatment," dated August 12, 2016, the policy and procedure indicated, b. Pressure Injury and Other Skin Reports: c. A skin integrity progress report will be initiated when a resident is admitted with or develops a skin problem such as skin tear ... d. There will be one pressure injury progress report, skin ulcer progress report or skin integrity progress report for each individual skin problem. C. Pressure and Other Skin Integrity Treatments: c the physician and family will be notified when there is a change in the condition of the pressure injury or skin integrity. E. IDT-Skin Committee will document discussion and recommendations for: 1. All skin integrity problems that do not respond to treatment, worsen, or increase in size ... During a review of a facility policy and procedure titled "Comprehensive Person-Centered Care Planning" revised, November 2018, the policy and procedure indicated b. additional changes or updates to the comprehensive care plan will be made based on the assessed needs of the resident ... c. The comprehensive care plan will be periodically reviewed and revised by IDT after each assessment ... In addition, the comprehensive care plan will also be reviewed and revised at the following times: I. Onset of new problems. II. Change of condition; ...	F 686		

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F 686	Continued From page 6 V. IDT Care Planning Conference c. The care planning meeting will be documented on NP-04-Form A-IDT Conference Record.	F 686		

Novato Healthcare Center October 25, 2023

POC: TSBH11

Novato Healthcare Center Novato Healthcare Center submits this response and Plan of Correction
as part of the requirements under state and federal law. The plan of correction is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this plan of correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider or its employees, agents, officers, directors, or shareholders. The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are related upon in a manner adverse to the interests of the provider either by the governmental agencies or third party.

What corrective action(s) will be accomplished for the patient(s) identified to have been affected by the deficient practice

Resident 2 did not readmit back to the facility. Resident 2 discharged from the facility on 4/8/2022, prior to the CDPH visit on 10/9/2023.

How other patients having the potential to be affected by the same deficient practice be identified, and what corrective action will be taken.

All in-house residents with wounds were immediately reviewed and assessed. Assessments for those wounds were communicated to the following Physician and to the Wound Doctor for treatment recommendations. Care plans reviewed and updated. All was completed by 10/25/23.

What immediate measures and systemic changes will be put in place to ensure that the deficient practice does recur.

The Director of Staff Development in-serviced Certified Nursing Assistants on the process of identifying and reporting any pressure sores or open areas that they find on residents while providing care, to the charge nurse, immediately. Once the Licensed Nurse was made aware of the pressure ulcer or open area, the licensed nurse will assess the site and report to the DON,

Treatment Nurse, the following Physician, and the Wound Doctor for treatment recommendation.

Treatment Nurse is assigned seven days a week, which allows for that nurse to solely focus on wound care. A Certified Wound Doctor rounds weekly with the Treatment Nurse to review wounds. Based on the assessment of the Wound Doctor, the Wound Doctor will make recommendations for treatment. The Treatment Nurse will update care plan and treatment orders as needed after weekly rounds by Wound MD. The Director of Staff Development in-serviced Licensed Nurses, Certified Nursing Assistants, and Interdisciplinary Team regarding comprehensive care planning. All in-services were completed by 10/25/23.

A description of the monitoring process and positions of persons responsible for monitoring (i.e., Administrator, Director of Nursing, or other responsible supervisory personnel). How the facility plans to monitor its performance to ensure corrections are achieved and sustained. The plan of correction must be implemented, corrective action evaluated for its effectiveness, and it must be integrated into the quality assurance system.

In addition to weekly rounding by the Wound Doctor, the Director of Nursing has a weekly wound meeting with the Treatment Nurse, Director of Rehab, Registered Dietician, Assistant Director of Nursing, and Social Services, to review the most recent wound report. During the meeting, recommendations are reviewed, interventions discussed, new follow up items from the Wound Doctor are identified and implemented with a care plan update. The Director of Nursing, or Assistant Director of Nursing, along with the Treatment Nurse, immediately assess new wounds, pressure sores, or skin related issues upon notification. Treatment nurse or DON/ADON communicate these new sites to the MD, and Wound Doctor. This will be on-going; however, this process was put into place by 10/25/23.

Dates when corrective action will be completed. The corrective action completion date must be acceptable to the department. The deficient practice should be corrected immediately. This date shall be no more than 30 calendar days from the date the facility was notified of the non-compliance.

The Administrator and DON will present the results and progress of the wound program to the Quality Assurance and Performance Improvement for review and recommendations monthly for 3 months or until substantial compliance is achieved. All training and compliance for this plan of correction was completed by October 25, 2023.

Revision #1