

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

PRINTED: 04/11/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/05/2022
NAME OF PROVIDER OR SUPPLIER  WILLOW PASS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3316 WILLOW PASS ROAD CONCORD, CA 94519		
(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 the investigation of a complaint.  Complaint number: CA00761629.  Representing the California Department of Public Health: HFEN 32717.  The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.  Two deficiencies were written as a result of complaint CA00761629.	F 000			
F 686 SS=G	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, for one of three sampled residents (Resident 1), the facility failed to ensure Resident 1 received treatment	F 686	Corrective Action  Facility will make sure that when any resident admit or readmit from the hospital, wound measurements and assessments will be done on a timely manner to ensure the healing process of the wounds is happening as expected in case of any discrepancy, facility will consult the physician and adjust the treatments accordingly.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Y. S. [Signature]*

TITLE

*Administrator*

(X6) DATE

4/29/22

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.

RECEIVED

POC acceptable 6/23/22 C.M.A., HFES

JUN 16 2022

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

PRINTED: 04/11/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/05/2022
NAME OF PROVIDER OR SUPPLIER  WILLOW PASS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3318 WILLOW PASS ROAD CONCORD, CA 94519		
(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 686	Continued From page 1  and services consistent with professional standards of practice to promote healing of a pressure ulcer (otherwise known as bed sore, a skin injury that result from unrelieved pressure on a body part, usually on a bony prominence like the tailbone, buttocks and hips) and prevent new pressure ulcers from developing when:  -the facility staff did not continuously provide assessment, monitoring and physician ordered treatment to an existing Stage II (partial thickness skin loss that involves the deeper layers of the skin, may appear as a shallow crater) pressure ulcer on the coccyx (tailbone). This failure resulted in the worsening of Resident 1's pressure ulcer from Stage II to Stage IV (full thickness skin loss with extensive destruction, tissue necrosis [tissue death], or damage to bone, muscles or tendons); and -the facility staff did not provide treatment and did not monitor the development of a new Stage II pressure ulcer on the left buttock. This failure had the potential to result in delayed management and treatment of the pressure ulcer.  Findings:  Review of Resident 1's Admission Record indicated, Resident 1 was initially admitted to the facility on 9/4/19 with diagnoses that included dementia (memory loss and impaired decision making ability), low back pain and osteoarthritis (protective tissue at the end of the bones wear down, causes pain in the hands, neck, lower back, knees and hips).  Review of Resident 1's Situation, Background, Appearance, Review (SBAR, a communication tool among health practitioners) Communication	F 686	Facility will also ensure that there is a weekly wound assessment done as well.  Any resident under wound care, facility will make sure there is an adequate care plan developed.  Facility will follow up and ensure that there is enough staff for the treatments and following up all treatment orders on a timely manner.  DON in consultation with RD will make sure that there are recommendations for the weight loss and proper follow ups.		4/29/22

RECEIVED

JUN 16 2022

Licensing & Certification  
East Bay District Office

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

PRINTED: 04/11/2022  
FORM APPROVED  
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/05/2022
NAME OF PROVIDER OR SUPPLIER  WILLOW PASS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3316 WILLOW PASS ROAD CONCORD, CA 94519		
(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 686	Continued From page 2  Form and Progress Note, dated 12/19/21 Indicated, Resident 1 was transferred to the acute hospital due to low oxygen saturation (amount of oxygen in the blood) level reading of 81 percent (%, normal range is 95% to 100%) at room air. The Progress Note indicated Resident 1 had a primary diagnosis of COVID 19 (a respiratory infection caused by a coronavirus that could have severe or life threatening complications).  Review of Resident 1's Nursing Admission Screening/History, dated 12/27/20, indicated Resident 1 was re admitted to the facility from the hospital with a Stage II pressure ulcer on the coccyx. The Nursing Admission Screening/History did not indicate measurement of Resident 1's pressure ulcer on the coccyx. Resident 1 was re admitted on hospice care (compassionate care focusing on the quality of life so that the person's last days may be spent with dignity and quality).  During an interview and concurrent review of Resident 1's Nursing Admission Screening/History, dated 12/27/20, and Weekly Wound Observation Tool, dated 1/19/21, with Registered Nurse Consultant (RNC), on 2/8/22, at 2:56 p.m., RNC stated, Resident 1's pressure ulcer should have been measured for the staff to know the baseline and to be able to monitor whether the wound is worsening or improving, that way, appropriate treatment and intervention could be provided. RNC stated, aside from the Weekly Wound Observation assessment dated 1/19/21, Resident 1's clinical record did not indicate a wound assessment was done after 1/19/21. RNC stated there should have been a weekly wound assessment for every pressure ulcer.	F 686	Facility will make sure all pressure ulcers are promptly documented and followed up.  Clinical team will ensure that facility will follow the policy & procedures all the time.  Weekly wound progress follow up with patient/responsible party timely manner.  Identify Other Residents.  Other residents who have wounds may have a potential to be affected by this deficient practice.		4/29/22

RECEIVED

JUN 16 2022

Licensing & Certification  
East Bay District Office

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

PRINTED: 04/11/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/06/2022
NAME OF PROVIDER OR SUPPLIER  WILLOW PASS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3318 WILLOW PASS ROAD CONCORD, CA 94619		
(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)	(X6) COMPLETION DATE	
F 686	Continued From page 3  Review of Resident 1's Braden Scale for Predicting Pressure Sore Risk, dated 12/27/20, indicated Resident 1 was at "High Risk" for developing pressure ulcer.  Review of Resident 1's Minimum Data Set (MDS, an assessment tool used to direct resident care), dated 1/5/21, indicated Resident 1 had a Stage II pressure ulcer and was at risk of developing pressure ulcer.  During an interview and concurrent review of Resident 1's clinical record with Treatment Nurse (TN), on 2/8/22, at 11:20 a.m., TN stated, there was no pressure ulcer care plan to address Resident 1's pressure ulcer despite a high pressure sore risk based on Braden Scale assessment and MDS assessment. TN stated licensed staff should have developed a pressure ulcer care plan.  Review of Resident 1's Skin Impairment Assessment by Hospice Nurse (HN) 1 dated 12/27/20, indicated, Resident 1's Stage II pressure ulcer on the coccyx measured 2.1 centimeters (cm) x 1.4 cm x 0.1 cm. The skin assessment indicated, "Noted with [Stage II] pressure injury to coccyx treatment initiated cleanse pressure injury to coccyx with NS [normal saline] pat dry apply med honey [medihoney, used to treat partial to full thickness pressure ulcers with moderate amount of drainage] cover with [dry] dressing daily until healed."  Review of Resident 1's Treatment Administration Record (TAR) for December 2020 indicated there was no treatment done on Resident 1's coccyx pressure ulcer for three days from 12/27/20 to 12/29/20. The TAR indicated that treatment order	F 686	DON and Nursing supervisor in conjunction with treatment nurses made a team and started working on the skin and wounds on a daily basis.  After the morning meeting clinical team will join and go through the IDT notes, weekly notes, wound assessments, measurements on a daily basis. Facility will ensure that there is a consistent treatment nurse every day.	4/29/22	

RECEIVED

JUN 16 2022

Licensing & Certification  
East Bay District Office

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

PRINTED: 04/11/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/05/2022
NAME OF PROVIDER OR SUPPLIER  WILLOW PASS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3318 WILLOW PASS ROAD CONCORD, CA 94519		
(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 686	Continued From page 4  for medihoney, as initiated by HN 1 on 12/27/20 was not carried out. Review of a telephone visit by Hospice Nurse 4 (HN 4), titled, "Visit Note LVN," dated 12/28/20, indicated current treatment for Resident 1's coccyx pressure ulcer was to apply wound gel and cover with dry dressing.  Further review of Resident 1's TAR for December 2020 indicated wound gel treatment order for the coccyx pressure ulcer, as indicated in hospice "Visit Note LVN" dated 12/28/20, was not initiated until 12/30/20.  Review of Resident 1's Medication Review Report for January 2021 indicated an order dated 12/27/20 to "Apply skin barrier to peri area (between genitals and anus) as preventative measure every shift". Another order dated 12/30/21 indicated, "Sacral [a large, triangular bone at the bottom of the spine and between the two hip bones] coccyx: Cleanse with NS, pat dry, apply wound gel (treatment of choice for minor, superficial/partial thickness wounds such as a Stage II pressure ulcer), cover with a dry dressing every day shift". The report did not indicate the treatment initiated by HN 1 on 12/27/20 (day of re-admission) to apply medihoney on the pressure ulcer.  During an interview and concurrent review of Resident 1's clinical record with TN, on 2/8/22, at 1:09 p.m., another Braden Scale for Predicting Pressure Sore Risk dated 1/7/21 indicated Resident 1's pressure sore risk went down from "High Risk" (from 12/27/20 assessment) to "Moderate Risk". TN stated the assessment of Resident 1's sore risk was not accurate and written by "Maybe one of the registry nurses who would just throw in numbers". TN stated,	F 686	Nursing supervisor and DONs are more hands on and involved with all the complicated wounds treatments directly.  Facility did in-service with the charge nurses including treatment nurse regarding proper wound treatments.  DON and Nurse Consultant planning to continue the in-service  Systemic Changes As a systemic change facility is in the process of changing the wound physician group who does weekly rounds on weekly basis with a new group with modern wound healing equipments and methods.  Staff educated on the skin management program and change in condition within emphasis on weekly and daily skin integrity checks by license nurses and CNAs		4/29/22

RECEIVED

JUN 16 2022

Licensing & Certification  
East Bay District Office

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

PRINTED: 04/11/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/05/2022
NAME OF PROVIDER OR SUPPLIER  WILLOW PASS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3318 WILLOW PASS ROAD CONCORD, CA 94519		
(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 686	<p>Continued From page 5</p> <p>Resident 1's Nutritional Screening dated 1/6/21 indicated Resident 1 had poor appetite and consumed only soups during meals, an information that would have increased Resident 1's risk.</p> <p>Review of RD (Registered Dietician) Note dated 1/7/21 indicated, under skin, "Pressure ulcer. No pressure injuries and no edema per nursing weekly summary 5/6." RD's recommendation was for monthly weight monitoring per hospice protocol. There was no recommendation for nutritional intervention to address an existing pressure ulcer.</p> <p>During an interview and concurrent review of Resident 1's Weekly Wound Observation Tool, dated 1/19/21, with TN, on 2/8/22, at 1:09 p.m., the observation tool indicated Resident 1's pressure ulcer on the sacrococcyx (fused tailbone and sacrum, the triangular bone just above the tailbone) area was a Stage II that measured 3.5 cm x 3.5 cm, unable to determine depth. The tool indicated Resident 1's wound was "Worsening" and had slough (yellow, tan, white stringy tissue). TN stated, the pressure ulcer should not have been a Stage II because of the presence of slough that indicated wound is worse than a Stage II. The tool listed the current treatment plan as; cleanse with normal saline, pat dry and apply medihoney to wound bed and cover with dry dressing. The licensed staff who completed the observation tool and signed off on the TAR was not available for interview.</p> <p>Review of Resident 1's "Visit Note LVN" dated 1/19/21, indicated "[HN 4] Spoke with tx [wound treatment] nurse. New left buttock wound deteriorating."</p>	F 686	<p>License nurses will complete skin assessment on each resident at the time of admission and as needed.</p> <p>Weekly wound assessment and document findings in the weekly progress notes for the current wounds.</p> <p>New treatment nurse joined with the facility who is focusing more into the complicated wounds. She will be send to the wound certification.</p> <p>Facility clinical team is doing a special emphasis on treatment, wound measurements &amp; assessments.</p>	4/29/22	

RECEIVED

JUN 16 2022

Licensing & Certification  
East Bay District Office

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

PRINTED: 04/11/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/05/2022
NAME OF PROVIDER OR SUPPLIER  WILLOW PASS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3318 WILLOW PASS ROAD CONCORD, CA 94519	
(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 686	Continued From page 6  Review of Resident 1's Physician's Order from hospice dated 1/19/21 indicated to change the treatment to Resident 1's left buttock and coccyx pressure ulcers to; "Cleanse with NS, pat dry, and apply medihoney. Then cover with a foam dressing daily."  Review of Resident 1's TAR for January 2021 indicated physician ordered treatments from hospice for the existing pressure ulcer on the coccyx and the new pressure ulcer on the left buttock were not provided from 1/19/21 to 1/31/21.  Review of Resident 1's TAR for February 2021 indicated the physician ordered treatment from hospice for Resident 1's left buttock pressure ulcer was not provided from 2/1/21 to 2/11/21.  Review of Resident 1's Skin Impairment Assessment by Hospice Nurse (HN) 2 dated 2/9/21 indicated Resident 1 had two pressure ulcers, one with an open date of 12/27/20, and a new one with an open date of 2/9/21. The assessment indicated the following: #1, open date 12/27/20, coccyx area, Stage IV pressure injury that measured 3.5 cm x 3.5 cm x 0.4 cm. #2, open date 2/9/21, left buttock area, Stage II pressure injury that measured 2.5 cm x 1.7 cm x 0.1 cm.  During a telephone interview with Registered Nurse Supervisor (RNS) on 3/14/22 at 2:53 p.m., RNS stated Resident 1's clinical record did not have any documentation of a new open area on left buttock.	F 686	Monitoring Process  DON will monitor for compliance on a weekly bases.  Nursing consultant will review & Audit in a monthly basis to ensure the system is working as expected.  QA Process  This plan of correction will be integrated to monthly QA system.  POC will be reviewed during the CQI meeting for compliance.  Completion Date  Plan of correction will be completed on 04/30/2022	4/29/22

RECEIVED

JUN 16 2022

Licensing & Certification  
East Bay District Office

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

PRINTED: 04/11/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/05/2022
NAME OF PROVIDER OR SUPPLIER  WILLOW PASS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3318 WILLOW PASS ROAD CONCORD, CA 94519		
(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 686	<p>Continued From page 7</p> <p>Review of Resident 1's Health Status Notes dated 2/12/21 indicated Resident 1 died on 2/11/21.</p> <p>Review of Resident 1's Situation, Background, Appearance, Review (SBAR, a communication tool among health practitioners) Communication Form and Progress Note, dated 12/19/21, indicated, Resident 1 was transferred to the acute care hospital due to low oxygen saturation (amount of oxygen in the blood) level reading of 81 percent (%; normal range is 95% to 100%) at room air. The Progress Note indicated Resident 1 had a primary diagnosis of COVID 19 (a respiratory infection caused by a coronavirus that could have severe or life threatening complications).</p> <p>During a telephone interview with Hospice Nurse (HN) 3 on 2/9/22 at 3:02 p.m., HN 3 stated, on 2/11/21, when Resident 1 died, Resident 1's pressure on the sacrococcyx area looked "big and really bad" and had odor to it. HN 1 also stated, there was part of the ulcer that was black.</p> <p>During an interview and concurrent review of the facility's undated "T time" (turning schedule, when residents are turned and repositioned) schedule with TN on 2/8/22 at 1:09 p.m., TN stated, for all residents who had pressure ulcers, T Time was implemented. TN stated all staff, licensed nurses and Certified Nursing Assistants (CNAs), made rounds every two hours to make sure residents were in a certain position while in bed (i.e., at 2:00 p.m., residents were to face the window, at 4:00 p.m., the residents were to be on their back, etc.). TN stated, because T time was universal for all residents regardless of where the pressure ulcer was located, it was not applicable for Resident 1</p>	F 686		4/29/22	

RECEIVED

JUN 16 2022

Licensing & Certification  
East Bay District Office



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

PRINTED: 04/11/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/05/2022
NAME OF PROVIDER OR SUPPLIER  WILLOW PASS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3318 WILLOW PASS ROAD CONCORD, CA 94519		
(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 686	<p>Continued From page 8</p> <p>because of the location of the ulcer. TN stated, Resident 1 was to be positioned on the back only to eat, otherwise, Resident 1 should be on either side to reduce pressure on the buttock area and tailbone. Review of the facility's T time would have Resident 1 positioned on the back, two hours at a time, for a total of over nine hours a day.</p> <p>During an interview with Restorative Nursing Assistant (RNA) 1 on 2/8/22, at 2:48 p.m., Resident 1 was one of the residents who was turned and repositioned every two hours because Resident 1 required total assist with all activities of daily living (like turning and repositioning while in bed). RNA 1 stated, around lunch time, residents that included Resident 1, needed to be on their back, after two hours, they were repositioned to face the window.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, "Wound and Skin Management," released on 9/1/08, the P&amp;P indicated all staff are responsible for the prompt reporting of any skin related problems and any resident who has pressure sores will receive the necessary treatment and services to promote healing and prevent ulcers from developing. The P&amp;P indicated under assessments, the procedures included, licensed nurse will assess each resident's skin condition weekly and document findings in the weekly progress notes and/or the skin sheet. Interdisciplinary team (IDT, a group composed of individuals representing different departments of the facility) and licensed nurse will assure care plans and progress notes reflect resident's current status and appropriate interventions. Licensed nurse will refer newly identified pressure ulcer to IDT for further</p>	F 686		4/29/22	

RECEIVED

JUN 16 2022

Licensing & Certification  
East Bay District Office

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

PRINTED: 04/11/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/05/2022
NAME OF PROVIDER OR SUPPLIER  WILLOW PASS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3318 WILLOW PASS ROAD CONCORD, CA 94519		
(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)	(X6) COMPLETION DATE	
F 686	Continued From page 9  assessment and care planning. The P&P also indicated, licensed nurses will document pressure ulcer status at least every seven days and should record the status of the ulcer, location, size and stage. IDT will enter all skin related issues on the resident's care plan and there will be an interdisciplinary approach to skin care.	F 686			
F 849 SS=E	Hospice Services CFR(s): 483.70(o)(1)-(4)  §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.  §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:	F 849	Corrective Actions  Facility will make sure that whenever a resident admitted to the hospice service, IDT will meet and develop a care plan and the team will make sure that this care plan is followed up and resident care adequately met.  Facility will ensure that whenever a patient admitting to the facility who requires a wound treatment daily, facility will ensure that wound treatments are done as orders by the physician.  We will pay more emphasis on the residents whose risk score is high in developing pressure ulcers; we will ensure that wounds treatments are done on a daily basis.	4/29/22	

RECEIVED

JUN 16 2022

Licensing & Certification  
East Bay District Office

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

PRINTED: 04/11/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/06/2022
NAME OF PROVIDER OR SUPPLIER  WILLOW PASS HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3318 WILLOW PASS ROAD CONCORD, CA 94519	
(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 849 Continued From page 10

- (A) The services the hospice will provide.
- (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
- (C) The services the LTC facility will continue to provide based on each resident's plan of care.
- (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
- (E) A provision that the LTC facility immediately notifies the hospice about the following:
  - (1) A significant change in the resident's physical, mental, social, or emotional status.
  - (2) Clinical complications that suggest a need to alter the plan of care.
  - (3) A need to transfer the resident from the facility for any condition.
  - (4) The resident's death.
- (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
- (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
- (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs

F 849

Treatment nurses will be in-serviced on how to clear slough and do the correct wound measurements and apply the treatments as prescribed by the physician.

Nurses will be in-serviced on the importance of developing a care plan on a timely basis especially with the residents who has high risk score.

Facility will make sure that there will be all the IDT members are present to develop a care plan; in case of a hospice resident we will ensure there is hospice representative present.

IDT will contact Hospice and make a new plan to meet with them on a weekly basis to discuss the care issues. Especially for the residents with more complicated issues like wounds

4/29/22

RECEIVED

JUN 16 2022

Licensing & Certification  
East Bay District Office

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

PRINTED: 04/11/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/05/2022
NAME OF PROVIDER OR SUPPLIER  WILLOW PASS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3318 WILLOW PASS ROAD CONCORD, CA 94519		
(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 849	Continued From page 11 necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.  §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.	F 849	Identify other residents  Other residents who have wounds may have a potential to be affected by this deficient practice.  DON and Nursing supervisor in conjunction with treatment nurses made a team and started working on the skin and wounds on a daily basis.  After the morning meeting clinical team will join and go through the IDT notes, weekly notes, wound assessments, measurements on a daily basis. Facility will ensure that there is a consistent treatment nurse every day.  Nursing supervisor and DONs are more hands on and involved with all the complicated wounds treatments directly.	4/29/22	

RECEIVED

JUN 16 2022

Licensing & Certification  
Division

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

PRINTED: 04/11/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/05/2022
NAME OF PROVIDER OR SUPPLIER  WILLOW PASS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3318 WILLOW PASS ROAD CONCORD, CA 94519		
(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 849	Continued From page 12 The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.	F 849	Facility will involve hospice nurses more when developing care plans for the hospice residents, nursing supervisor will sure that IDT is complete when doing IDT meetings  Facility did some in-service with the charge nurses including treatment nurse regarding proper wound treatments.  Systemic Changes  Facility made some systemic changes to improve hospice services at the facility.  DON in conjunction with the nursing supervisor developed a new team to ensure that hospice is providing adequate care for the residents who are under hospice care. New team consists of CNAs, Charge Nurses, Social Service Director, Nursing supervisor & DON.	4/29/22	

RECEIVED

JUN 16 2022

Licensing & Certification  
East Bay District Office

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

PRINTED: 04/11/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/05/2022
NAME OF PROVIDER OR SUPPLIER  WILLOW PASS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3318 WILLOW PASS ROAD CONCORD, CA 94519		
(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 849	Continued From page 13  §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on interview and record review, for one of three sampled residents (Resident 1), the facility failed to coordinate Resident 1's care, who was on hospice (compassionate care focusing on the quality of life so the person's last days may be spent with dignity and quality), when the facility did not have a designated interdisciplinary team (IDT, a group composed of individuals representing different departments of the facility) member responsible for working with hospice staff to provide quality of care to Resident 1 and Resident 1's family, and a care plan was not developed and implemented regarding pressure ulcer (a skin injury that result from unrelieved pressure on a body part, usually on a bony prominence like the tailbone, buttocks and hips)  These failures resulted in Resident 1 developing a new pressure ulcer and Resident 1's pressure ulcer on the coccyx (tailbone), worsened from Stage II (partial thickness skin loss that involves the deeper layers of the skin, may appear as a shallow crater) to Stage IV (full thickness skin loss with extensive destruction, tissue necrosis [tissue death], or damage to bone, muscles or tendons). (Refer to F686)  Findings:	F 849	More Hospice Involvement  Part of the new systemic changes Facility IDT will meet with Hospice team on a weekly basis and discuss the progress of residents under hospice. Any discrepancies will address immediately.  Facility will closely monitor the patients care by hospice in all areas including the hospice aid visits, nurse's visits, social service visits and Chaplin visits extra. Team will make sure that during the visits they are meeting the needs of the residents.  Any discrepancies will bring it to the attention of the DON and Social Service Director right away. Facility will contact the hospice company immediately to correct the deficient practice.  Corporate Nurse Consultant will monitor for compliance on a weekly basis through her audits.  Braden scale to be completed on all residents to identify resident on high risk to develop pressure sores.	4/29/22	

RECEIVED

JUN 16 2022

Licensing & Certification  
East Bay District Office

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

PRINTED: 04/11/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/05/2022
NAME OF PROVIDER OR SUPPLIER  WILLOW PASS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3318 WILLOW PASS ROAD CONCORD, CA 94518		
(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 849	Continued From page 14  Review of Resident 1's Admission Record indicated, Resident 1 was initially admitted to the facility on 9/4/19 with diagnoses that included dementia (memory loss and impaired decision-making ability), low back pain, and osteoarthritis (when protective tissue at the end of the bones wear down, causes pain in the hands, neck, lower back, knees and hips).  Review of Resident 1's Situation, Background, Appearance, Review (SBAR, a communication tool among health practitioners) Communication Form and Progress Note, dated 12/19/21, indicated, Resident 1 was transferred to the acute care hospital due to low oxygen saturation (amount of oxygen in the blood) level reading of 81 percent (%), normal range is 95% to 100%) at room air. The Progress Note indicated, Resident 1 had a primary diagnosis of COVID-19 (a respiratory infection caused by a coronavirus that could have severe or life-threatening complications).  Review of Resident 1's Nursing Admission Screening/History, dated 12/27/20, indicated Resident 1 was re-admitted to the facility from the hospital with a Stage II pressure ulcer on the coccyx and on hospice care.  Review of Resident 1's Skin Impairment Assessment by Hospice Nurse (HN) 1, dated 12/27/20, indicated, on 12/27/20, the day Resident 1 was re-admitted to the facility, Resident 1's Stage II pressure ulcer on the coccyx measured 2.1 centimeters (cm) x 1.4 cm x 0.1 cm. The skin assessment by HN 1 indicated, "Stage II pressure injury to coccyx treatment initiated cleanse pressure injury to		F 849, Facility clinical team is doing a special emphasis on treatment, wound measurements & assessments.  Facility will work with only few hospice companies who are responsible and providing adequate care for the residents.  Monitoring Process  Wound care nurse (Treatment Nurse) will monitor skin management program for compliance  DON will monitor for compliance on a weekly bases.  Nursing consultant will review & Audit on a weekly basis to ensure the system is working as expected.	4/29/22	

RECEIVED

JUN 16 2022

Licensing & Certification  
East Bay District Office

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

PRINTED: 04/11/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/05/2022
NAME OF PROVIDER OR SUPPLIER  WILLOW PASS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3318 WILLOW PASS ROAD CONCORD, CA 94519		
(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 849	Continued From page 15 coccyx with [normal saline] pat dry apply medhoney [medihoney, used to treat partial to full thickness pressure ulcers with moderate amount of drainage] cover with dry dressing daily until healed."  Review of Resident 1's Braden Scale for Predicting Pressure Sore Risk, dated 12/27/20, indicated Resident 1 was at "High Risk" for developing pressure ulcer.  Review of Resident 1's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 1/5/21 indicated, Resident 1 had a Stage II pressure ulcer and was at risk of developing pressure ulcer.  Review of Resident 1's Treatment Administration Record (TAR) for December 2020 indicated there was no treatment done on Resident 1's coccyx pressure ulcer for three days from 12/27/20 through 12/29/20. The TAR indicated treatment order for medihoney, as initiated by HN 1 on 12/27/20, was not carried out.  Review of a telephone visit by HN 4, titled "Visit Note LVN," dated 1/19/21, indicated the presence of a new left buttock pressure ulcer and Resident 1's coccyx wound was deteriorating.  Review of Resident 1's Weekly Wound Observation Tool dated 1/19/21 indicated, Resident 1's pressure ulcer on the sacrococcyx area (fused tailbone and sacrum, the triangular bone just above the tailbone) Stage II pressure ulcer measured 3.5 cm x 3.5 cm, depth was unable to be determined because of the presence of slough (yellow, tan, white stringy tissue). The Weekly Wound Observation Tool, under	F 849	QA Process  This plan of correction will be integrated to monthly QA system.  POC will be reviewed during the CQI meeting for compliance.  Completion Date  Plan of correction will be completed on 04/30/2022		

4/29/22

RECEIVED

JUN 16 2022

Licensing & Certification  
East Bay District Office



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

PRINTED: 04/11/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/05/2022
NAME OF PROVIDER OR SUPPLIER  WILLOW PASS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3318 WILLOW PASS ROAD CONCORD, CA 94519		
(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)	(X6) COMPLETION DATE	
F 849	Continued From page 16  "Evaluation" indicated the pressure ulcer was "worsening" and listed the current treatment as; cleanse with normal saline, pat dry, apply medihoney and cover with dry dressing.  Review of Resident 1's Physician's Order from hospice, dated 1/19/21, indicated to change the treatment on Resident 1's left buttock and coccyx pressure ulcers to "Cleanse with NS, pat dry, and apply medihoney. Then cover with a foam dressing daily."  Review of Resident 1's TAR for January 2021 indicated physician-ordered treatments from hospice for the existing pressure ulcer on the coccyx and the new pressure ulcer on the left buttock dated 1/19/21 were not provided from 1/19/21 to 1/31/21.  Review of Resident 1's Skin Impairment Assessment by HN 2, dated 2/9/21, indicated, Resident 1 had two pressure ulcers, one with an open date of 12/27/20, and a new one, with an open date of 2/9/21. The assessment indicated the following: -#1, coccyx area, open date 12/27/20, Stage IV pressure injury measured 3.5 cm x 3.5 cm x 0.4 cm. -#2, left buttock area, open date 2/9/21, Stage II pressure injury measured 2.5 cm x 1.7 cm x 0.1 cm.  During an interview and concurrent review of Resident 1's clinical record with Treatment Nurse (TN), on 2/8/22, at 11:20 a.m., TN stated there was no pressure ulcer care plan to address Resident 1's pressure ulcer despite a Resident 1's high pressure sore risk based on Braden Scale assessment and MDS assessment that	F 849			

4/29/22

RECEIVED

JUN 16 2022

Licensing & Certification  
East Bay District Office

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

PRINTED: 04/11/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/06/2022
NAME OF PROVIDER OR SUPPLIER  WILLOW PASS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3318 WILLOW PASS ROAD CONCORD, CA 94519		
(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 849	Continued From page 17  indicated a Stage II pressure ulcer. TN stated the staff should have initiated a pressure ulcer care plan. TN also stated the Plan of Care (POC), dated 1/14/21, from hospice, was not current and was obtained by the facility more than two weeks after identification of the pressure ulcer.  During an interview with TN, on 2/8/22, at 12:43 p.m., TN stated, every time a resident enters the facility with a pressure ulcer, there should be a treatment plan that could change every 14 days depending on the status of the wound, whether it is improving with current treatment or if the wound is worsening.  During a telephone interview with Hospice Administrator (HA), on 2/11/22, at 2:31 p.m., HA stated, the expectation was for the admitting hospice nurse to leave a report to a facility staff before ending the visit.  During a telephone interview with TN, on 3/15/22, at 10:40 a.m., TN was not able to identify the designated IDT member who coordinated Resident 1's care with hospice. TN stated there was a care conference meeting among Minimum Data Set Assessment Coordinator (MDS), Kitchen Manager (KM) and Resident Representative (RR) 1 but without a hospice representative.  During a telephone interview with MDS, on 3/15/22, at 10:45 a.m., MDS stated the hospice representative communicated with whoever was the licensed nurse on the floor at the time of the visit. MDS denied being the designated IDT member to coordinate Resident 1's care with hospice representative.	F 849		4/29/22	

RECEIVED

JUN 16 2022

Licensing & Certification  
East Bay District Office

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

PRINTED: 04/11/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/05/2022
NAME OF PROVIDER OR SUPPLIER  WILLOW PASS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3318 WILLOW PASS ROAD CONCORD, CA 94519		
(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 849	<p>Continued From page 18</p> <p>During a telephone interview with Kitchen Manager, on 3/15/22, at 1:25 p.m., KM stated she attended the care conference but was not the IDT member designated to coordinate with the hospice representative. KM also stated there was no hospice representative present during the care conference.</p> <p>During a telephone interview with HA, on 3/15/22, at 3:04 p.m., HA stated, Resident 1's hospice record indicated for in-person and telephone visits, the hospice staff discussed Resident 1's treatment plan with whoever was the licensed nurse in charge of Resident 1 at the time.</p> <p>Review of the facility's policy and procedure (P&amp;P) titled, "Wound and Skin Management," released on 9/1/08, indicated, the P&amp;P indicated, all staff are responsible for the prompt reporting of any skin related problems. Any resident who has pressure sores will receive the necessary treatment and services to promote healing and prevent new ulcers from developing. The P&amp;P indicated, Interdisciplinary Team and licensed nurse will assure care plans and progress notes reflect resident's current status and interventions. The licensed nurse will refer any new pressure ulcer to IDT for care planning. The P&amp;P indicated, IDT will enter all skin-related issues on the resident's care plan and if resident or resident representative choose comfort care only, the care plan should reflect agreed upon goals and interventions.</p>	F 849			

4/29/22

RECEIVED

JUN 16 2022

Licensing & Certification  
East Bay District Office