STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **056280**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **05/26/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR HEALTHCARE CENTER OF OAKLAND	**2919 FRUITVALE AVE OAKLAND, CA 94602**

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 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide services for untreated and unassesed skin ulcers, and untreated pain for four residents (1, 3, 13, 14) of 19 sampled residents and two additionally sampled (29, 30) resulting in the neglect of residents' (1, 3, 13, 29, 30) skin ulcers resulting in the residents being placed at risk for infection and neglect of residents (3, 14)who did not receive pain medications timely. Resident 1 had physician's orders [REDACTED]. skin, bones, possibility of losing his leg and at risk for infection due to the lack of nursing care as prescribed by his physician. Resident 3 was placed on Hospice (end of life) care and did not receive medications and pressure ulcer care as ordered. She went without [MEDICATION NAME] (narcotic pain relief medication) for 19 hours when it was to be given every four hours, and her open pressure ulcers went untreated. The nurses did not follow doctor's orders for Hospice care resulting in Resident 3 suffering from pain and agitation due to not receiving Hospice medication, and not receiving pressure ulcer treatment. Resident 13 was paralyzed and had extensive pressure ulcers to his buttocks and upper thighs. He was exhibiting symptoms of illness and his family insisted he be sent to the hospital. He was sent to the ER where the doctor documented they found the resident covered in feces from his mid back to his upper thighs, and was subsequently place in the intensive care unit [MEDICAL CONDITION] (potentially life threatening complication of an infection). Resident 14 was admitted to the facility with orders for a medication to treat his pain which was not provided by the facility resulting in Resident 14 stating he felt like he was going to die if if he did not get his medication. He called 911 to take him to the hospital in order to obtain his medication. During the extended survey on 5/20/15 and 5/21/15, two additional residents were found to have ulcerated skin that was not assessment or treated. Resident 29 had an open pressure ulcer on his right elbow which was identified by the Occupational Therapist (OT) and reported to the DSD. The DSD did not notify the physician, obtain treatment orders or treat the resident's open area which put him at risk for further breakdown and/or infection. Resident 30 had a pin (metal rod) in his left lower leg (through the skin bone) that had an open area around the pin site and was on antibiotic medication to treat a bone infection at the site. There was a doctor's order for pin care which was not clarified as to what pin care was needed. The wound around the pin had some depth, was crater shaped, was moist with yellow tissue, and loosely covered with a gauze wrap. (Cross-reference F226) The RAdmin was notified of the Immediate Jeopardy (IJ) on 5/4/15 at 10:40 a.m. RAdmin provided the team a written Plan of Correction for IJ of Neglect on 5/4/15. The items listed, such as discontinuing electronic records and starting paper based medication and treatment records, training of all nurses, admission audits etc. were not immediately feasible. The IJ could not be lifted by the end of the standard survey, which was then extended due to substandard care. The RAdmin was notified again by telephone on 5/13/15 at 10:54 a.m. of the IJ and to make corrections. During the extended survey on 5/20/15 and 5/21/15, items 5. and 6. were identified. The facility managers, including RAdmin were informed during the exit conference on 5/26/15 at 2:45 p.m. that the IJ could not be lifted because of the continued neglect in not caring for Resident 29 newly aquired pressure ulcer and not following up on physician's orders [REDACTED]. During an on-site visit on 6/8/15 the IJ was abated and at 11:30 a.m. the Administrator was informed in an exit conference. Findings: 1. On 4/16/15 at 2:20 p.m. the facility was entered to investigate an anonymous complaint (4) regarding Resident 1 feeling afraid he would lose his leg because his wound dressings were not changed and not receiving his intravenous (IV) antibiotic (administered into the vein) as ordered, because of lack of a registered nurse (RN) in the facility. (RNs are the only licensed nurses who can administer IV antibiotics.) On 4/16/15 at 2:20 p.m., Resident 1 was observed sitting up in his wheelchair by the foot of the bed in his room where he was watching television. His right heel was wrapped in a gauze bandage that was brown with red drainage. At 2:40 p.m., LVN 3 who came to the resident's room, stated that she was the charge nurse. When LVN 3 was asked if Resident 1 was to have his dressing changed, LVN 3 stated that she didn't know because he goes out for his treatments. LVN 3 did not look at Resident 1's foot and walked out of the room. LVN 3 went to the nursing station to check if Resident 1 had a doctor's order for treatment. The DON found an order in the paper chart which had not been entered into the computer for the nurses to implement. The physician's orders [REDACTED]. The order was for daily cleansing with normal saline, wound gel (ointment to treat pressure ulcers) and dressings to his sacral (back)wounds and daily cleaning with normal saline and Santyl ointment ([MEDICATION NAME] agent to remove dead tissue) and cover with dry gauze to his right heel wound. Those orders were dated 4/6/13. At 3 p.m., the DON was observed measuring and dressing Resident 1's wounds. Resident 1 was placed in his bed, and the dressing from his right heel was unwrapped and revealed a malodorous wound covering the entire area of Resident 1's heel. The wound measured 8 cm by 8.4 cm with a depth of 1 cm, and was reddened with some areas of yellow slough (necrotic tissue). His buttocks was assessed and there were no dressings covering the left inner buttock which had a 6 cm by 2 cm stage 2 pressure ulcer (Partial thickness loss of skin, presenting as a shallow open ulcer with a red-pink wound bed) and the right inner buttock had a 2.5 cm by 3 cm stage 2. His right upper thigh just below his buttocks had many scattered small areas of skin breakdown. In addition, the skin on his back was dry and dead skin was flaking off onto the bed. According to a review of the medical record on 4/17/15, Resident 1 had been a resident of the facility since 11/23/13. He had [DIAGNOSES REDACTED]. In February 2015, Resident 1 had an infection of the right foot ulcer and was prescribed three different antibiotics intravenously at the facility. According to his MDS assessment dated [DATE] he was totally dependent on two persons to transfer from his bed to the wheelchair, and needed assistant to move about his room and the facility. He needed extensive assistance for bathing and personal hygiene, was occasionally incontinent of urine and frequently incontinent of bowels. He was at risk of developing pressure ulcers and had a [MEDICAL CONDITION] as well as moisture associated skin damage (i.e. incontinence, perspiration, drainage). During an interview on 4/17/15 at 3:10 p.m., the DSD stated that on Monday (4/13/15), Resident 1 came to the DSD office and asked him to change his dressing. The DSD said he only did the right heel dressing and then told the Station 3 charge nurse that he did it, but he did not document it. He also said he did the dressing to his heel that was ordered when he was working as the treatment nurse and he did not look to see if there were any new orders for treatment. According to a nurses' note dated 4/17/15 at 4:40 p.m., the DSD wrote the following late entry note for 4/13/15: Resident

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 0224

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 1)
(1) came by my office requesting to have his dressing changed for his RIGHT HEEL pressure wound ONLY .When I checked on patient's order's for clarification of his wound care order, the previous order was only present, but from DON's previous statement to me, resident would no longer be on wound vac (vacuum dressing using negative pressure to promote healing). Since there was no actual treatment order for resident, I could not clarify the order .I only did a simple dressing change which was clean with normal saline, pat dry, apply foam dressing and cover with gauze roll .Wound was only foul smelling with dressing, after cleaning wound and getting rid of the old dressing, there was no foul smell .
On 4/27/15 at 3 p.m., Resident 1 was sitting up in his wheelchair with his right foot wrapped in a pillow case. The DON and a nurse consultant (NC 1) came in the room and unwrapped the resident's foot. His foot was swollen and the gauze bandage was wrapped around his ankle so that the under part of his heel wound was uncovered and exposed.
A review of the April 2015 Treatment Administration Record (TAR) showed Resident 1 had four different treatment orders for the right heel ulcer. The physician's orders [REDACTED]. The TAR reflected a new treatment order on 4/20/15 for, Right Heel: Clean with normal saline, pat dry apply silver alginate (antimicrobial highly absorbent dressing) over wound bed, non-adherent oil [MEDICATION NAME] gauze (dressing that won't stick to the wound tissue) over wound, wrap with 2 layer compression. Change three times a week .every Mon, Wed, Fri. The order from 4/6/15 had not been verified by the physician or transcribed onto the TAR. The DON confirmed in an interview on 4/27/15 at 3:30 p.m. that no treatment had been performed between 4/16/15 and 4/20/15 when she discovered that nobody processed the order discovered on 4/16/15. The DON stated that on 4/20/15 she asked DSD to call the doctor to get a treatment order.
DDS wrote a progress note on 4/20/15 1:52 (Late Entry date not specified) as follows: Resident requested to have dressing on his right heel pressure ulcer dressing to be change from me. I agreed to change his dressing .I also asked if he would like me to do the treatment for [REDACTED].
During a telephone interview with the wound care nurse (WCN 2) at the wound clinic on 4/24/15 at 10:30 a.m. she stated that Resident 1 had been coming into the wound care center and his bandage was not being changed at the facility. She notified the facility to let them know that it needed changing and they said he was refusing. She said that Resident 1 was there on 4/23/15 and his next appointment was set for 4/30/15. He only goes to the clinic once a week, and his orders for treatment of [REDACTED].
In a telephone interview with Resident 1's physician (MD 1) on 4/30/15 at 3:40 p.m. she stated that the resident was non-compliant with his wound care and that the facility staff were saying that the resident refused treatment, and Resident 1 said that the staff weren't doing the dressing changes. She said she could not figure out who was telling the truth.
(Cross reference F278 #1)
2. The state agency received a complaint (4) regarding Resident 3 not receiving pain medication (liquid [MEDICATION NAME]), [MEDICATION NAME] (antipsychotic medication) and treatment of [REDACTED]. The staff recorded that [MEDICATION NAME] was
given even though it was in a sealed box.
On 5/4/15 at 11:45 a.m. Resident 3 was observed lying in bed with her daughter at her side. Resident 3's daughter said that her mother had been in the facility since last July 2014 and was placed under Hospice care recently. She said the physician ordered [MEDICATION NAME] for pain every four hours, and the Hospice nurse came in on 4/29/15 and found that the [MEDICATION NAME] had not been given for 14 hours. Resident 3's daughter said her mother had been in a lot of pain. She also said that now that the resident is getting her pain medication and the [MEDICATION NAME], she is better, quiet and resting.
The Hospice nurse (HRN) stated in an interview at the facility on 5/5/15 at 9:30 a.m., that she was upset with the facility nurses because they had not implemented the hospice physician's orders [REDACTED]. They did not carry out the orders for a [MEDICATION NAME] (narcotic pain medication in a patch that delivers the medicine through the skin), [MEDICATION NAME] for
her agitation, and she couldn't tell if the Resident had a bowel movement because there was none charted. Also the resident had pressure ulcers on her sacrum and the orders for treatment had not been carried through. HRN had to instruct the facility nurse to give the medications and do the treatment, she even laid the treatment bandages out on the treatment cart for the nurse to do.
Review of the medical record revealed that Resident 3, a [AGE] year old female was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED].) by mouth in the morning and 1 ml (2 mg) in the evening for agitation .New orders for wound care were written on 4/23/15, wound # 1 sacrum (above the tail bone) to do wound care three times a day and more if needed, cleanse with warm soap and water, apply barrier cream (cream to protect the skin from moisture). The same was written for wound # 2 on the coccyx (tail bone).
According to the Hospice Clinical Note dated 4/24/15, Resident 3 was described as .in bed, stiff, non-verbal. Yells if touched .Unable to get BP D/T (blood pressure due to) stiffness and combativeness. The plan had been for the staff nurse to assess .monitor and mitigate pain with MS around the clock and as needed. The HRN wrote, Intervention performed by clinician. Coordinated with Facility RN and DON about the importance of transcribing orders and giving meds for comfort as ordered. DON will transcribe orders herself. Pt (patient) is comfortable and not in any distress.
The Hospice Clinical Note dated 4/29/15 revealed that The LVN today reported that she has not been giving any [MEDICATION NAME] on her shift because she did not know where it was. I worked with her to find it in the cart with the box still sealed. The medication had not been given up to this point. The record also reflected a new area on the right heel deep tissue injury, (wound #3) and orders for facility nurse to paint with skin prep (a liquid that's applied skin to form a protective film) three times a day until healed, and float the heels at all times while in bed.
The Hospice Clinical Note dated 4/30/15 revealed that, Patient was in pain when I arrived. When I went to look at the MAR (medication administration record) to see when or if Pt had a MS dose, I found in the Narcotic Count Book, that the patient had not had [MEDICATION NAME] since 9 p.m. last night. The nurses had been documenting that they had been giving the medication in the electronic MAR but not administering the medication to the patient. Then the Nurse (RN 4) reported the patient had been refusing the doses. Requested a dose be given immediately and then put back to bed. HRN's note continued to reveal, Wound care orders written on 4/28 and 4/29 were not carried out and the treatment nurse knew nothing about them. Waited to ensure the orders were carried out and the initial treatment were done.
On 4/30/15 at 3:30 p.m. the physician ordered a [MEDICATION NAME] 12 micrograms (mcg) to be applied to the back of her arm every 72 hours for pain. An order dated 5/2/15 changed the order to discontinue current 12 mcg [MEDICATION NAME] by removing it. Add [MEDICATION NAME] 12 mcg apply 2 patches (24 mcg) to back of her arm every 72 hours for pain. Once 24 mcg
[MEDICATION NAME] placed, discontinue routine [MEDICATION NAME] and continue the [MEDICATION NAME] on an as needed basis.
HRN's Clinical Note dated 5/3/15 revealed that, Routine visit today to do skin assessment, wound care, check MD orders, and pain assessment. When I arrived the order from 5/1 and 5/2 had not been transcribed. Patient was still on the old order of [MEDICATION NAME] 12 mcg every 72 hours and that patch was due to be changed today. The physician's orders [REDACTED]. The
HRN note dated 5/3/15 revealed the actions of the HRN, I changed the [MEDICATION NAME]es per MD order .Ensured the [MEDICATION NAME] routine was stopped at 8 p.m. tonight in the electronic MAR.
(re: Complaint 9)

3. The Department of Public Health received a complaint (4) on 4/13/15 alleging Resident 13 was sent to the acute hospital on [DATE] without the staff assessing or checking on him from 8:00 p.m. until the time the ambulance arrived. He was sent to the acute hospital soaked with fecal material extending from his lower back to his knees.
On 4/27/15, review of Resident 13's closed record showed Resident 13 was originally admitted to the facility on [DATE], and readmitted on [DATE] after a stay in the acute hospital from 2/11/15 thru 4/7/15. His readmission [DIAGNOSES REDACTED].
LVN 1 documented in the progress notes on 4/10/15 at 10:58 p.m., that while Resident 13's father and sister were visiting, his father came to the nursing station and asked if someone had visited his son (Resident 13)and gave him some drugs. He returned to the nursing station and reported his son was in pain. He came back to the nursing station and reported his son was having chest pain.
LVN 1 documented without a specific time in the progress notes on 4/10/15 that he went to Resident 13's room and assessed Resident 13 for changes in his vital signs such as an in increase pulse rate, blood pressure, and respiratory rate, and change in cardiac rhythm. He documented only the changes observed, Resident 13's blood pressure was 76/48 (normal blood pressure 120/80). He went back and checked on Resident 13 and his blood pressure was still low. He notified the doctor who ordered transfer of Resident 13 via 911 to the acute hospital for further evaluation and treatment. According to the nurses notes, Resident 13 was transferred to the acute hospital via 911 ambulance on 4/10/15 at 10:20 p.m.

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F 0224

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 2)
Review of the acute hospital Emergency Department Notes dated 4/10/15 at 11:13 p.m., showed Resident 13 was just recently discharged from the hospital five days prior and now returned with [MEDICAL CONDITION] (low blood pressure), altered mental status (any measure of arousal other than normal) and rigor (shivering and chills). The ER notes indicated Resident 13 had developed with what appeared to be [MEDICAL CONDITION] (potential life threatening infection) or septic shock, (a condition that occur when a body wide infection lead to dangerous low blood pressure). Resident 13's abdomen was distended (swollen), [MEDICAL CONDITION] bag full of white brown stool and gas. According to the ER notes, Resident 13 arrived covered with feces from upper legs and to mid-torso and soiled dressing on the multiple skin ulcerations and had massive stage 4 decubitus ulcers (Full thickness tissue loss with exposed bone, tendon or muscle, slough (layer of skin off) or eschar (dead tissue) may be present on some parts of the wound bed) extending up to mid-[MEDICATION NAME] (middle back) spine covered in feces with pus draining from at least one area on the right buttock.
The acute hospital History and Physical report documented that Resident 13 was admitted to intensive care unit on 4/10/15 for treatment of [REDACTED].
The hospital surgery consultant wrote on 4/11/15, Resident 13 was known to have a large stage four pressure sore that required a loop [MEDICAL CONDITION] a couple weeks ago and the loop [MEDICAL CONDITION] did not completely divert the stool
resulting in leakage of stool through the rectum, contaminating his sacral wounds.
A second review of Resident 13's closed record at the facility on 5/6/15 showed that the facility did not developed a plan of care to monitor Resident 13 [MEDICAL CONDITION] bag or to monitor him for regular bowel movements from his rectum.
Review of Resident 13's closed record on 4/27/15 showed that on 4/10/15 the wound doctor assessed his pressure sores at the facility. She wrote treatment orders for the staff to cleanse the wounds with normal saline, pat dry and apply Silver alginate (used to assist with management of infected wounds), cover with dry clean dressing daily to the stage four pressure sores on his lower back, left and right ischium (sitting bone), sacrum (bone at the bottom of the spine); his right and left heel, and the stage three pressure sore (Full thickness tissue loss. Subcutaneous (under the skin) fat may be visible) to his left and right lower leg.
The treatment sheet was reviewed and showed orders dated 4/8/15 instructing the staff to cleanse Resident 13's pressure sores with normal saline, pat dry, apply calcium alginate dressing(used on wounds that ooze bodily fluids) and cover with Meplex (a foam dressing that absorbs wound fluid) dressing one time a day. There was no indication on the treatment sheets the staff did any treatments on April 8, 9 and 10, 2015 to Resident 13's stage IV pressure sore on his lower back, left and right ischium, right and left heel and the stage III pressure sore back of his left and right lower leg. The treatment sheet further revealed that the staff did not implement the new treatment orders the wound doctor ordered for Resident 13's pressure sores on 4/10/15.
During an interview on 4/27/15 at 3:00 p.m., Nurse consultant 1 was not able to show where the treatment orders the wound doctor wrote on 4/10/15 for Resident 13's pressure sores were transcribed to the new sheet.
During an interview on 5/15/15 at 2:00 p.m. Resident 13's sister said, That evening (4/10/15) when we went to visit my brother (Resident 13) he didn't recognize us. My father thought something was wrong with him. So he asked the nurse if something was wrong or if he (Resident 13) had taken some kind of drugs.
On 5/6/15 at 8:45 a.m. during an interview at the facility, C.N.A. 7 was asked about Resident 13's condition prior to going to the acute hospital on [DATE]. C.N.A. 7 said, I never changed him. When I came in at 3:00 p.m. I did rounds. He had his head covered. There was nothing in his [MEDICAL CONDITION] bag. I told the nurse he (Resident 13) didn't want to be touched and his bag was empty. Later when (Resident 13's) parents got here they told the charge nurse he was shaking and not himself.
During an interview with LVN 1 on 5/6/15 at 3:40 p.m. he said, The (Resident 13's) father came in and went to the room and then came to the nursing station and said someone came and gave him drugs. After a few minutes I went into the room to see what the father was talking about. The father came back and said Resident 13 was complaining of pain. I medicated him for pain. He was ok he was talking. The [MEDICAL CONDITION] bag was closed. The father came back and said he was complaining of
chest pain. I went to assess him his blood pressure was low. I gave him his medication for low blood pressure. I checked his blood pressure again and it was still low. I asked him how he was feeling, he said so, so. I called the doctor and the doctor said transfer him to the hospital, 911. When the paramedic were transferring him from the bed to the gurney, I seen the bowel movement on the bed. I told the paramedic he had a [MEDICAL CONDITION] bag. I said the bag may have open that's why the feces is there. I told them to wait but they were rushing to take him. When LVN 1 was asked about Resident 13 having stools from his rectum he said, I'm not aware of that, he has a [MEDICAL CONDITION]. That was my first day working with him since he came back from the hospital. No one told me he was having stools from his rectum.
(Cross reference F281 #2) (re: Complaint 4)
4. During an interview on 5/4/15 at 2:30 p.m., Resident 14 said, When the hospital was ready to discharge me back to my facility (Facility B) but they said they have an infection and no one could come in. They asked me to come here until the infection clear up. When I came here they told me they would have some of my medication but not all of my medication. The next day the nurse didn't have my [MEDICATION NAME] ([MEDICATION NAME]). I told the nurse if she couldn't give me my medication I would have to go to the hospital. They didn't give me my medication. I was hurting, so, I called my facility (Facility B) and they told me if they can't give me the medication to call 911. So I called 911.
Review of Resident 14's record revealed he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].
During an interview on 5/7/15 at 8:30 a.m., LVN 3 said, The C.N.A. told me the morning of 5/3/15 he (Resident 14) wanted his medication. I checked if his medication had arrived. None had arrived. I went to his room and told him his medication had not arrived, so he said , I need my medication. Let me go to the hospital. I told him I called the pharmacy, the doctor, and Facility B where he had been. He (Resident 14) said he needed his [MEDICATION NAME]. He was shaking and felt like he was going to die. I called the pharmacy and they said it would be on the 8:00 a.m. delivery today. I called the doctor and told him we needed authorization to use the [MEDICATION NAME]. The doctor told me he would call the pharmacy and give authorization. The Resident didn't want to wait so he called 911. The pharmacy called and did not give authorization [MEDICATION NAME] because we didn't have the dosage in the emergency kit.
During an interview on 5/7/15 at 1:30 p.m. the pharmacy consultant said, They could have taken the medication from the emergency kit. They have five and ten milligram of [MEDICATION NAME] in the kits.
During an observation of the medication storage on 5/6/15 at 2:30 p.m. with the California Department of Public Health Pharmacy and the facility's DON, the emergency medication kit had eight tablets of [MEDICATION NAME] 5 mg and 10 tablets of [MEDICATION NAME] 10 mg.
LVN 3 documented in the progress notes on 5/3/15 at: 8:30 a.m. Resident 14 complained of feeling shaky and That he was going to die if he did not get his medication. She explained to him that the medication were ordered last night and would arrive today.
At 9:30 a.m. Resident 14 called 911, the ambulance arrived and took him to the acute hospital. At 11:00 a.m. the acute hospital called and said they would give him his [MEDICATION NAME]. At 3:43 p.m. Resident 14 was transported back to he facility from the acute hospital.
Review of the Pharmacy shipment summary record showed that on 5/3/15 at 2:10 p.m. the facility received 35 tablets of [MEDICATION NAME] 10 mg.
(Cross reference F431 #5) (re: Complaint 9)
5. Resident 29 was admitted to the facility on [DATE] for treatment of [REDACTED].
According to the wound assessment dated [DATE] at 2:45 Resident 29 had a stage IV pressure ulcer on his coccyx (tailbone) that was 0.7 cm by 0.4 cm with a depth of 0.4 cm.
During an observation and interview at the bedside on 5/21/15 at 12 p.m., Resident 29 was having his right arm placed in a splint by the Occupational Therapist (OT) and her assistant. The OT told the assistant not to put the splint on over his elbow, and Leave the wound open. The resident had a round open area that presented as a shallow crater over the bony area of his outer elbow. The OT stated that she had told the DSD about the sore on 5/20/15.
A review of the medical record revealed that there was no new pressure sore on the right elbow identified, and there was no treatment ordered. The wound was uncovered and unattended.
In an interview with DSD on 5/21/15 at 4 p.m. he said that he was unaware of a new pressure sore on Resident 29.
The DSD returned and provided a Non-Pressure Skin Condition Report that revealed Resident 29 had a right elbow skin tear first observed on 5/20/15 that was measured on 5/21/15 to be 1 cm by 0.7 cm with a depth of 0.1 cm. The DSD could not

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F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) explain why a round open area over a bony prominence on a limb that had been splinted would be documented as a skin tear. 6. Resident 30 was admitted to the facility on [DATE] for trauma aftercare of a fractured lower left leg, and rehabilitation. On 5/20/15 at 2:45 p.m. Resident 30 was sitting up in his wheelchair in his room. His left foot was wrapped in an elastic bandage with a metal pole that protruded up the front of his leg that was attached to a metal pin that went through the front of his shin bone. The area where the pin and pole connected there was a thin piece of gauze covering his leg. The resident pulled the gauze aside to reveal an open sore around the pin area with had depth and was moist and yellow. He said, they were putting some antibiotic ointment on it. In an interview with the DSD on 5/20/15 at 4:10 p.m. he stated that he was waiting for iodine/[MEDICATION NAME] to come in. He said that the order for pin site care came from the hospital and the resident was to go back in two weeks for an appointment. He presented the order that was from a doctor's visit on 5/14/15 that reflected, .Pin site care daily with dressing changes. We will see him in one week. He is to start a 2 week course of abt. (antibiotic) The DSD further stated that he did not clarify the order with the prescribing physician, nor did he call the attending physician to receive and start the order. He also did not perform a skin assessment, nor was he aware of the open area at the pin site. A review of the Treatment Record (TAR) for May 2015 revealed that the resident's treatment beginning 5/15/15 was for pin site care daily and as needed at the left foot, to clean with hydrogen peroxide solution, apply gauze pads around pin site, and monitor for signs and symptoms of an infection every shift. On 5/2/15 there was an entry added, Clean pin sites with NSS (normal saline solution) pat dry then cover with gauze, change PRN (as needed) soiled.
F 0278 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure each resident receives an accurate assessment by a qualified health professional.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that the MDS was accurate for two (1, 4) of 19 sampled residents and one (36)of 18 additionally sampled residents. For Resident 36 the MDS did not include her psychiatric diagnoses. This contributed to Resident 36 not receiving the appropriate health professionals involved to develop a plan of care that would include monitor and assessing her for behavior problems and behavior changes. Resident 36 was eventually transferred from the facility via 5150 after becoming agitated and combative with staff and another resident. Resident 1's MDS did not accurately document his behavior problems of rejecting care and treatment. This resulted in the facility not being prompted to develop an appropriate plan of care for Resident 1's rejecting care and treatment. For Resident 4 the MDS was inaccurate for speech clarity, making self understood and understanding others. This placed Resident 1 at risk of not receiving her needed care. Findings: 1. The Department of Public Health received complaint number 0 that Resident 36, was outside the facility going through the garbage to find food to eat. Resident 36's record was reviewed on 5/21/15 during the facility's extended recertification survey from 5/20 through 5/21/15. According to the face sheet Resident 36 was admitted to the facility on [DATE]. The record review showed that the staff assessed Resident 36 on the annual MDS assessment form dated 5/7/15. On the MDS under section I (active [DIAGNOSES REDACTED]. only [DIAGNOSES REDACTED]. The physician progress notes [REDACTED].). Review of the facility's plan of care for Resident 36 revealed no care plan for the staff to monitor her for behaviors related to her [MEDICAL CONDITION] diagnoses. The nurses notes revealed the following documentation: 1. On 5/9/15 at 3:00 a.m. Patient was wandering the halls until about 2:00 a.m. She's sleeping inside the shower room in station 2. 2. On 5/13/15 at 4:15 p.m. read, Resident went outside to the garbage area by the back of the facility. Encourage resident to get back into the facility and to her room, but she refused. 3. On 5/15/15 at 2:45 p.m.,At 2:15 p.m. resident was agitated and threw a bedside table at the C.N.A. and roommate. She then kept yelling and pacing around room . MD(medical doctor) order to be sent out 5150. During an interview with the MDSC on 5/26/15 at 2:00 p.m. she stated the other MDSC completed Resident 36 MDS she is not working here today. During an interview with LVN 5 on 5/21/15 at 3:00 p.m. she stated, She (Resident 36) would eat out of the garbage and eat feces also. She would get mad if you stopped her. Read her record it's a lots of documentation about her doing this. During a telephone interview with LVN 5 on 5/29/15 at 11:30 a.m. said, She (Resident 36) had anxiety, depression, and I believe an eating disorder. I looked in her record one day, and she didn't have a psychiatric diagnoses. 2. According to a review of the medical record on 4/17/15, Resident 1 was a [AGE] year old man who had been a resident of the facility since 11/23/13. He had [DIAGNOSES REDACTED]. According to his MDS assessment dated [DATE] he was totally dependent on two persons to transfer from his bed to the wheelchair, and needed assistant to move about his room and the facility. He needed extensive assistance for bathing and personal hygiene. He was occasionally incontinent of urine and frequently incontinent of bowels. He was at risk of developing pressure ulcers and had a [MEDICAL CONDITION] as well as moisture associated skin damage (i.e. incontinence, perspiration, drainage). The areas for mood and behavior were assessed as no problems, and in particular the area of Rejection of Care - Presence and Frequency. According to the MDS the behavior was not exhibited during the assessment period. A review of the nurses progress note dated 2/20/15 at 9:13 a.m. revealed, Resident refused wound appointment today at . Another nurses note dated 2/2015 at 6:27 p.m. revealed, Patient alert and oriented on antibiotic for right foot pressure ulcer infection. Patient was upset that it was smoke break time and he was on I.V. receiving antibiotic. Patient said that he was going to pull the I.V. out of his arm, because he did not want to miss the smoke break time . The nurse also noted on 2/20/15 at 7:41 a.m. an unnamed medication was refused. Resident 1 has an outside health maintenance organization that manages his care and provides medical oversight. On 4/29/15 at 12:20 p.m. the Clinical Director (CD) stated in a telephone interview that Resident 1 had been their client for years and was non-compliant with his wound care. He had refused over 75 times to go to their clinic. 3. The facility admitted Resident 4 on 1/11/12 with a [DIAGNOSES REDACTED]. (dementia: decline in memory or thinking skills) In an observation on 5/5/15 at 1:37 p.m., licensed certified nursing assistants were observed turning Resident 4 in bed. Resident 4 expressed difficulty hearing and understanding staff questions and comments. Resident 4's verbal responses to staff were unintelligible. (could not be understood) Record review on 5/28/15 at 3:09 p.m. of the document titled, MDS 3.0 (comprehensive physical and psychosocial assessment), dated 4/25/15, showed Resident 4 had clear speech and was usually able to express ideas and wants to staff. Further review of the MDS showed a brief interview to assess Resident 4's mental status was not done due to the fact that Resident 4 was, Rarely/never understood. The section of the MDS titled, Problem Area: 04, Communication, showed the following: Resident 4 had difficulty understanding verbal content and was hearing impaired. (had difficulty hearing) (psychosocial assessment: assessment of one's ability to know where they are, what the date is, what their name is, and their ability to communicate, to make their needs known, to follow commands) Record review of the section of the MDS titled, Preferences for Customary Routine Activities, showed Resident 4 was able to be interviewed for daily preferences. Questions presented to Resident 4 included: how important is it for you to choose what clothes to wear? How important is it for you to take care of your personal belongings or things? Resident 4's responses were listed as, Very important. In an interview on 5/5/15 at 1:25 p.m., the MDS Coordinator, (MDSC), was asked how, if Resident 4 was rarely/never understood and had difficulty understanding verbal content, was she able to answer these questions? The MDSC stated, I can't answer that. It does not make sense to me. Not sure why.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **056280**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **05/26/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR HEALTHCARE CENTER OF OAKLAND	**2919 FRUITVALE AVE OAKLAND, CA 94602**

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F 0278 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4)

F 0281

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

Make sure 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 nursing services to meet professional standards of quality for two residents (1, 13) in a sample of 19 and two unsampled residents (24, 29) which had the potential to cause harm.

Resident 1 was given Intravenous (into the vein) antibiotics by Non-Registered Nurses as required by the Business and Professions Code.

Resident 13 had a significant change in his condition requiring hospitalization in the intensive care unit for complications of an infection (Sepsis), and the licensed vocation nurse (LVN 1) did not recognize Resident 13's symptoms until a family member alerted the LVN.

Residents 24 and 29 received injections of medications intramuscularly (in the muscle tissue) rather than subcutaneously (under the skin in the fat tissue) as ordered and following the standards of practice for nursing medication administration.

For Resident 7, nurses incorrectly signed they gave the medication instead of the nurse who actually did give the medication

Complaint CA 519 was substantiated see example 5

Findings:

1. According to a review of the medical record on 4/17/15, Resident 1 was a [AGE] year old man who had been a resident of the facility since 11/23/13. He had [DIAGNOSES REDACTED]. In February 2015 he had an infection of the right foot ulcer and was receiving the following IV antibiotics: 2/15/15 [MEDICATION NAME] in D5W (5% [MEDICATION NAME] (sugar) in water) solution 500 mg/100ml one time a day until 2/28/15 for right foot ulcer infection; 2/15/15 [MEDICATION NAME] HCL Solution 500 mg two times a day until 2/28/15; 2/20/15 [MEDICATION NAME] HCL Solution 1 gm (1000 mg) two times a day for right foot ulcer infection until 2/28/15 (was increased from the 500 mg dose); [MEDICATION NAME]-Tazobactam in [MEDICATION NAME]
solution 3.375 gm/50ml every 6 hours for right foot ulcer infection until 2/28/15.

The following IV medications were documented on the MAR as being administer by LVNs:

LVN 20: Levofloxicin on 2/27/15 at 9:14 a.m.; [MEDICATION NAME] 1000 mg on 2/27/15 at 1:48 p.m.; Pipercillian-Tazobactam 3.75 gm on 2/27/15 at 12:03 p.m.

LVN 21: [MEDICATION NAME] 500 mg on 2/18/15 at 6:10 a.m.; 2/19/15 at 5:08 a.m., [MEDICATION NAME] 1000 mg/200 ml, on 2/24/15
at 4:24 a.m.; 4/25/15 at 3:32 a.m.; 3/15/15 at 7:28 a.m., 3/20/15 at 5:05 a.m.;
[MEDICATION NAME]-Tazobactam 3.75 gm on 2/18/15 at 6:10 a.m. and 6:12 a.m. (for midnight and 6 a.m. doses), 2/19/15 at 5:08 a.m. and 5:08 a.m. (for midnight and 6 a.m. doses), 2/24/15 at 4:24 a.m. and 6:19 a.m. (for midnight and 6 a.m. doses), 2/25/15 at 3:32 a.m. and 5:36 a.m. (for midnight and 6 a.m. doses).

LVN 22: [MEDICATION NAME] 500 mg on 2/15/15 at 12 p.m.; [MEDICATION NAME] 1000 mg, on 2/24/15 at 2:26 p.m.

LVN 23: [MEDICATION NAME] 1000 mg on 3/16/15 at 2:29 p.m.

LVN 2: [MEDICATION NAME] 1000 mg on 3/6/15 at 2:33 p.m.

(California Business and Professions Code 2860.5. A licensed vocational nurse when directed by a physician and surgeon may do all of the following:: (c) Start and superimpose intravenous fluids if all of the following additional conditions exist: (1) The nurse has satisfactorily completed a prescribed course of instruction approved by the board or has demonstrated competence to the satisfaction of the board. (2) The procedure is performed in an organized health care system in accordance with the written standardized procedures adopted by the organized health care system as formulated by a committee which includes representatives of the medical, nursing, and administrative staffs. Organized health care system, as used in this section, includes facilities licensed pursuant to Section 1250 of the Health and Safety Code, clinics, home health agencies, physician's offices, and public or community health services. Standardized procedures so adopted will be reproduced in writing and made available to total medical and nursing staffs.)

According to a letter from the Board of Vocational Nursing and Psychiatric Technicians dated September 29, 2004 clarifying the scope of practice for licensed vocational nurses (LVNs), Section 2542 and Section 2542.1 of the Vocational Nursing Rules and Regulations delineate the role of vocational nurses in relation to intravenous therapy. IV fluids were broken into two categories. Category I includes blood, blood products, vitamins, nutrients, and electrolytes; and Category II includes other medications including, but not limited to, anticoagulants or antibiotics. An LVN may start and superimpose Category I intravenous fluids .LVNs cannot administer intravenous medications via primary or secondary lines, and cannot access central lines (including peripherally inserted central catheters or midline catheters), but can change central line dressings.

(re: Complaint CA 519)

2. On 4/27/15, review of Resident 13's closed record showed Resident 13 was originally admitted to the facility on [DATE], and was readmitted to the facility on [DATE]. His readmission [DIAGNOSES REDACTED].

The facility progress notes dated 4/10/15 at 10:58 p.m. revealed that the facility did not recognized Resident 13 was experiencing a change in his condition until his father and sister came to the facility for a visit. The staff documented with the time out of chronological order that Resident 13's father entered the facility and came to nursing station and asked if someone had visited his son and gave him some drugs. His father returned to the nursing station and reported that Resident 13 was in pain. The staff documented that his routine pain medication was given. The staff did not document an assessment of Resident 13's pain . Resident 13's father came to the nursing station a third time and reported Resident 13 was complaining of chest pain.

LVN 1 finally documented that he went to Resident 13's room and assessed him. He assessed Resident 13 to have a low blood pressure of 76/48 (normal blood pressure 120/80). LVN1 called the doctor and the doctor ordered to transfer Resident 13 to the acute hospital emergency room via 911 ambulance.

According to the ER notes dated 4/10/15 Resident 13 arrived back to the hospital five days after discharged covered with feces from his upper legs and to mid-torso and soiled dressing on the multiple skin ulcerations. Massive stage 4 decubitus ulcers extending up to mid- [MEDICATION NAME] spine covered in feces with pus draining from at least one area on the right buttock. Resident 13's Abdomen was swollen his [MEDICAL CONDITION] bag was full of white brown stool and he was shivering with chills.

The surgery consultant wrote Resident 13 was known to have a large stage four pressure sore that required a loop [MEDICAL CONDITION] a couple weeks ago. The loop [MEDICAL CONDITION] did not completely divert the stool resulting in leakage of stool through the rectum, contaminating his sacral wounds.

The acute hospital History and Physical report documented that Resident 13 was admitted to intensive care unit that night on 4/10/15 for treatment of [REDACTED].

A second review of Resident 13's closed record on 5/6/15 at the facility showed that on 4/10/15 the wound doctor assessed Resident 13's pressure sores. She wrote new treatment orders for his stage four pressure sores on his lower back, left and right sacrum, right and left heel, and the stage three pressure sore to his left and right lower leg.

The treatment sheet was reviewed and showed the staff did not do the treatment on April 8,9 and 10, 2015 to Resident 13's, Stage four pressure sore on his lower back, left and right ischium, right and left heel and the stage 3 pressure sore back of his left and right lower leg.

The treatment sheet further revealed that the staff did not implement the new treatment orders the wound doctor ordered for Resident 13's pressure sores on 4/10/15 before he was discharged to the acute hospital.

During an interview on 4/27/15 at 3:00 p.m. Nurse consultant 1 was not able to show where the treatment orders the wound doctor wrote on 4/10/15 for Resident 13's pressure sores were transcribed to the new sheet.

During an interview on 5/15/15 at 2:00 p.m. Resident 13's sister said, That evening when we went to visit my brother (Resident 13) he didn't recognize us. My father thought something was wrong with him. So he asked the nurse if something was wrong or if he (Resident 13) had taken some kind of drugs.

On 5/6/15 at 8:45 a.m. during an interview at the facility, C.N.A. 7 was asked about Resident 13's condition prior to going

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F 0281

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 5)
to the acute hospital on [DATE]. C.N.A. 7 said, I never changed him.
During an interview with LVN 1 on 5/6/15 at 3:40 p.m. he said, The (Resident 13's) father came in and went to the room and then came to the nursing station and said someone came and gave him drugs. The father came back and said Resident 13 was complaining of pain. I medicated him for pain. He was ok he was talking. The [MEDICAL CONDITION] bag was closed. The father came back and said he was complaining of chest pain. I went to assess him his blood pressure was low. I gave him his medication for low blood pressure. I checked his blood pressure again and it was still low. I asked him how he was feeling, he said so, so. I called the doctor and the doctor said transfer him to the hospital, 911. When the paramedic were transferring him from the bed to the gurney, I seen the bowel movement on the bed. I told the paramedic he had a [MEDICAL CONDITION] bag. I said the bag may have opened that's why the feces is there. I told them to wait, but they were rushing to take him.
When LVN 1 was asked about Resident 13 having stools from his rectum he said, I'm not aware of that, he has a [MEDICAL CONDITION]. That was my first day working with him since he came back from the hospital. No one told me he was having stools from his rectum.
(Cross reference F224 # 3) (re: Complaints CA 704, CA 519)

Based on observation, interview, and record review, the skilled nursing facility failed to ensure that services met professional standards of quality for one (Resident 6) of 19 sampled residents. Resident 6 had developed an area of discoloration on the top area of both feet. Licensed facility nursing staff failed to assess and document the discoloration. This failure resulted in the staff's inability to effectively identify and track the status of the discoloration.
Findings:
The facility admitted Resident 6 on 3/29/11 with a [DIAGNOSES REDACTED]. (deformity caused by normally stretchy tissues in the muscles/tendons/joints that become non-stretchy and prevents normal movement)
During the initial tour on 5/4/15 at 11:03 a.m., Resident 6 was observed being weighed by the Restorative Nurse Assistant, (RNA). There was an approximately dollar-size area of dark blue discoloration noted on the top part of Resident 6's feet. The RNA was asked if she knew what the discoloration was. The RNA stated, No. I just do the weights.
In an interview on 5/5/15 at 1:15 p.m., Certified Nursing Assistant 8, (CNA 8), was asked about the discoloration on Resident 6's feet. CNA 8 stated he had observed it and, Reported it to LVN 5. I have been taking care of her, (Resident 6), for about 4 months. I have not noticed any other skin discoloration on her body. Only on her feet.
In an interview on 5/5/15 at 12:45 p.m., Resident 6's Licensed Vocational Nurse, (LVN 5), was asked about the discoloration on Resident 6's feet. LVN 5 stated a, Nursing Assistant brought this to my attention approximately two weeks ago. The doctor was notified and there was an order given to monitor it. LVN 5 was asked to describe how she monitors the discoloration. LVN 5 stated it was, On the TAR. (treatment administration record). LVN 5 was then asked to describe the steps taken when she first became aware of the discoloration. LVN 5 stated she, Just looked at it. LVN 5 was asked to describe the steps one should take when becoming aware of a change in status such as skin discoloration. LVN 5 stated, It depends on the area. Where did it come from? You would assess. I would check the circulation, color, location, and call the doctor.
Record review on 5/5/15 at 9:13 a.m., of the TAR dated 5/1/15 to 5/5/15, showed staff were to monitor the discoloration on every shift. There was a check mark in each box for each shift.
Record review of the nursing notes on 5/5/15 at 12:50 p.m. showed no documentation of the specific size, color, or location of the discoloration.
Record review on 5/15/15 at 10:27 a.m., of the facility's policy and procedure titled, Change of Condition Notification, dated 4/1/15, showed the, Licensed Nurse will assess the change of condition and determine what nursing interventions are appropriate. Before notifying the Attending Physician, the Licensed Nurse must observe and assess the overall condition utilizing a physical assessment and chart review. Notification to the attending physician will include a summary of the condition change and an assessment of the resident's vital signs and system review focusing on the condition and/or signs and symptoms for which the notification is required.

3. Review of the clinical record, on 5/5/15, showed Resident 24 was admitted to the facility with multiple [DIAGNOSES REDACTED].) Resident 24 had a physician's orders [REDACTED].)
During an observation, on 5/5/15 at 8:15 a.m., LVN (licensed vocational nurse) 6 administered Insulin (a medication used to treat diabetes) to Resident 24. LVN 6 cleaned Resident 24's abdomen with an alcohol wipe and injected the needle straight down into the abdomen.
(Humlin insulin is an intermediate-acting insulin with a slower onset of action and a longer duration of activity (up to 24 hours) than that of Regular human insulin. [MEDICATION NAME] N is for subcutaneous injection only. It should not be used intravenously or intramuscularly. (Reference: www.globalrph.com/intermediateactinginsulins
4. Review of the clinical record, on 5/20/15, showed Resident 29 was admitted to the facility 3/6/15 with multiple [DIAGNOSES REDACTED].)
During an observation and concurrent interview, on 5/20/15 at 9:50 a.m., LVN 16 administered [MEDICATION NAME] (a medication
that prevented blood clots) intramuscularly (deep into the muscle tissue) to Resident 29. LVN 16 stated, I didn't give SQ (subcutaneously). I forgot.
Record review, on 5/20/15, showed that Resident 29 had a physician's orders [REDACTED].)
([MEDICATION NAME] sodium . should be given by intermittent intravenous injection, intravenous infusion, or deep subcutaneous injection. The intramuscular route of administration should be avoided because of the frequent occurrence of hematoma {localized collection of blood, usually clotted} at the injection site.) (Reference: www.drugs.com/pro/[MEDICATION NAME].html
5. Review of the clinical record, on 5/4/15 at 1:30 p.m., showed Resident 7 was admitted to the facility with multiple medical [DIAGNOSES REDACTED].) Resident 7 had placement of a PICC (peripherally inserted central venous catheter, used for long- term fluid and medication administration) line on 5/5/15. The physician's orders [REDACTED].
During an observation, on 5/20/15 at 9:30 a.m., the DON (Director of Nursing) was preparing for the administration of IV [MEDICATION NAME] to Resident 7. The DON stated she was going to teach RN (registered nurse) 25 how to administer the medication. RN 25 observed as DON administered the [MEDICATION NAME]. Review of the MAR (medication administration record),
at 9:45 a.m., showed RN 25 had signed for administering the [MEDICATION NAME].
During a record review, on 5/20/15 at 11:15 a.m., the MAR showed Resident 7's 5/17/15 dose of IV [MEDICATION NAME] had been
given by LVN (licensed vocational nurse) 24. During a telephone interview, on 5/20/15 at 1:40 p.m., LVN 24 stated she did not give the [MEDICATION NAME] but signed the MAR indicating she had administered the medication.
In an interview, on 5/20/15 at 11:15 a.m., NC (Nurse Consultant) 3 stated, If you sign, you did it.
In an interview, on 5/20/15 at 1:15 p.m., RN 18 stated she administered the 5/17/15 dose of [MEDICATION NAME] to Resident 7 but did not sign the MAR.
Review of the facility's policy and procedure titled, Medication Administration, dated 1/1/12 indicated, The time and dose of the drug or treatment administered to the patient will be recorded in the patient's individual medication record by the person who administers the drug or treatment.
(re: Complaint CA 519)

F 0285

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

Coordinate assessments with the pre-admission screening and resident review program for mentally-ill and mentally-retarded patients.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on interview, and record review, the facility failed to accurately complete the [DIAGNOSES REDACTED]. Resident 36 did not receive her needed mental health screening, evaluation and treatment.
This failure resulted in Resident 36 becoming agitated and combative and eventually being transferred out of the facility via 5150. (5150 is a 72 hour involuntary psychiatric hospitalization .)

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F 0285

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

(continued... from page 6)
Deficiency below is the result of complaint number 0.
Findings:
The Department of Public Health received a complaint that Resident 36, was outside the facility going through the garbage to find food to eat. This complaint was investigated during the facility's extended recertification survey from 5/20 through 5/21/15.
During an interview with LVN 5, on 5/21/15 at 3:00 p.m. she said She (Resident 36) would eat out of the garbage and she eat feces also. She would get mad if you stopped her.
During an interview with the Administrator on 5/27/15 at 11:00 a.m. she stated did not know the person who signed the PASARR. He was not working in the facility when she started working.
A second review of Resident 36's record on 5/26/15 revealed that her PASARR form dated 5/6/13 next to mental illness [DIAGNOSES REDACTED].
The physician progress notes [REDACTED].
The review did not show that the facility had Resident 36 assessed by a mental health worker.
The staff documented in the nurses notes on 5/15/15 at 2:45 p.m.,at 2:15 p.m. resident (Resident 36) was agitated and threw a bedside table at the C.N.A. and roommate. She then kept yelling and pacing around room. MD (medical doctor) order to be sent out 5150.

F 0314

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on observation, interviews and record review, the facility failed to assess, plan and provide care for one (2) of 19 sampled residents and one (31) additionally sampled resident to ensure that they did not develop pressure sores and they received the appropriate treatment to promote healing.
Twenty five days after admission to the facility Resident 31 developed a pressure sore behind her ear which was not assessed, and the staff did not follow the doctor's order to treat the pressure sore. Resident 31 also had unasssed pressure sore on her right elbow and sacrum.
For Resident 2 the staff did not apply the foam dressing to her heels per manufacture guidelines, resulting in Resident 2 being at risk of the pressure ulcer to her heels progressing in size and stage.
Deficiency number 2 is the result of complaint number: CA 704.
Findings:
1. Review of Resident 31's record on 5/21/15 showed the Resident was admitted on [DATE]. Resident 31's [DIAGNOSES REDACTED].
She was admitted to the facility under hospice care (comfort care).
The staff documented in the admission progress notes on 4/23/15 at 9:31 p.m. that Resident 31 had no bruises, discoloration and no open skin observed
The staff assessed Resident 31 on a comprehensive admission MDS dated [DATE] and documented that Resident 31 had no speech, rarely/never understood or understand others, she had both long and short term memory problems and she required total assistance of one to two person with her activity of daily living.
The Physician order [REDACTED]. CNA may apply qs(every shift) and as needed for incontinent episodes.
The physician's orders [REDACTED]. On 5/18/15, physician instructed the to clean the open area behind Resident 31's left ear with normal saline, pat it dry ,then to cover with [MEDICATION NAME] dressing (an absorbent foam dressing) and to do this every three days or as needed if soiled or removed.
Physician order [REDACTED]. Change every three days or as needed if soiled or removed.
The record review revealed no assessment of the wound behind Resident 31's left ear.
On 5/21/15 at 12:30 p.m., Resident 31 was observed on her bed with her eyes. An interview was attempted with her, Resident 31 opened her eyes but did not respond to simple questions. She did not have a dressing on the wound behind her left ear. She was receiving oxygen, and the oxygen tubing was on the open wound behind her ear.
On 5/21/15 at 1:30 p.m., observation of the treatment to the wound behind Resident 31's left ear showed the wound was open, red with white tissue in the center. Her elbow was open and red. Her sacrum was open red surrounded by pink tissue.
LVN 5 did the treatment to Resident 31's left ear and said, I will call the doctor to get an order for [REDACTED]. LVN 5 was asked how did she think Resident 31 received the wound behind her ear and responded From the oxygen tubing.
LVN 5 was asked what stage the wound was back of Resident 31's ear she said, Stage three. She said, There is no treatment order for the open elbow or the open sacrum. She said there were no assessments in the record for the wound behind Resident 31's ear, the open area on her elbow and sacrum.
During an interview on 5/21/15 at 2:30 p.m. regarding Resident 31 open areas CNA 19 said, I put A and D ointment on her buttock this morning. The buttock was open yesterday. She didn't have dressing on her ear this morning when I started my shift.

2. The state agency received an anonymous complaint (4) regarding an unnamed resident who's bedsore is getting worse and the dressing was not being changed, the date on the dressing was from the prior week and the resident was not able to talk.
During an on-site visit on 4/27/14 at 12:30 p.m. Resident 2 was lying in bed on her back with both of her heels wrapped in gauze bandages dated 4/25/15. The treatment nurse, LVN 13 arrived in the room to do her treatment for [REDACTED]. She did not have the orders with her. She then cut away the gauze dressing on the left heel. There was a blue square foam stuck to the heel. LVN 13 said it was Blue Hydrofoam. She poured normal saline solution on the blue foam dressing, then pulled the dressing off which caused Resident 2 to flinch. The wound over the heel was bright red, bleeding and there was skin visible on the blue dressing. LVN 13 then place a new piece of the Blue Hydrofoam dressing over the wound and covered with a gauze wrap dressing. She did not moisten the dressing. The DON came in the room and proceeded to remove the guaze dressing over the right heel, and the blue foam dressing which after she poured normal saline solution and pulled it off the dressing contained yellowish debris, like dead skin. The heel had red open wound bed along side a dark brown/grey round area in the center of the wound. The DON placed the dry Blue Hydrogel foam dressing from the package, over the wound and wrapped it with a gauze dressing. LVN 13 and the DON did not moistened the blue foam dressings before applying them to the wound.
According to the medical record, Resident 2, an [AGE] year old female was admitted to the facility on [DATE]. According to the quarterly MDS dated [DATE], Resident 2 needed extensive assistance for bed mobility and was totally dependent for transfers between bed and chair. She had a [DIAGNOSES REDACTED].
The Patient Wound Assessment dated 4/17/15 the Wound Doctor wrote orders for the bilateral heel wounds to apply [MEDICATION NAME] blue every three days and soak with saline before changing!, and Do not pull tissue when removing soak with saline and gently remove.
The Patient Wound Assessment dated 4/21/15, the left heel measurements were 4 cm by 4 cm with 0.1 cm depth, scattered and wound type was pressure. The Wound Doctor who made the assessment wrote an order to cleanse the wound with normal saline solution and apply [MEDICATION NAME] blue every three days and cover with dry clean dressing. The right heel measurements were 7 cm by 4 cm with 0.2 cm depth. It was assessed as a venous wound. The order was to apply [MEDICATION NAME] blue every
3 days. Additional instructions given were, Soak well with saline before removal! .
According to the HydroferBLUE package insert, the [MEDICATION NAME] Blue is a [MEDICATION NAME] (capable of killing bacteria) sponge dressing. The instructions for use are as follows: Remove [MEDICATION NAME] Blue Dressing from the package, and thoroughly moisten it with sterile saline or sterile water. Once the [MEDICATION NAME] Blue Dressing is thoroughly moistened, squeeze out the excess liquid. Apply the dressing to the wound .Cover Hydrofer Blue Dressing with a secondary dressing to prevent displacement and to maintain moisture content .Do not allow the dressing to completely dry out. The dressing should be rehydrated as needed. If the [MEDICATION NAME] Blue Dressing dries out, rehydration with sterile saline or sterile water is recommended prior to removal.

F 0353

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

Have enough nurses to care for every resident in a way that maximizes the resident's well being.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **056280**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **05/26/2015**
NAME OF PROVIDER OF SUPPLIER **WINDSOR HEALTHCARE CENTER OF OAKLAND**		STREET ADDRESS, CITY, STATE, ZIP **2919 FRUITVALE AVE OAKLAND, CA 94602**	

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 0353

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 7)
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on observation, interview and record review the facility failed to provide sufficient Registered Nurses to administer intravenous (IV) antibiotics for two residents (1,7) in a sample of 20 both being treated for [REDACTED]. Resident 1 was receiving IV [MEDICATION NAME] which is primarily used to treat serious infections caused by gram-positive bacteria which are known or suspected to be resistant to other antibiotics. Resident 7 was receiving IV [MEDICATION NAME] and if doses are missed, may increase the risk of further infection that is resistant to antibiotics. (Reference: Drugs.com)
In addition to the missed [MEDICATION NAME] doses, Resident 1 received three IV antibiotics which were administered 22 times by five licensed vocational nurses (LVN 2, LVN 20, LVN 21, LVN 22, LVN 23). LVNs are not licensed by the state of California to administer medications intravenously, which could result in harm from improper administration, to the resident.
Findings:
The State Agency recieved complaints regarding nurse staffing problems and Resident 1 not recieving his IV [MEDICATION NAME]
due to the lack of an Registered Nurse (RN) to administer the IV medication. Complaint numbers: CA 864, CA 519.
1. According to a review of the medical record on 4/17/15, Resident 1 was a [AGE] year old man who had been a resident of the facility since 11/23/13. He had [DIAGNOSES REDACTED]. In February 2015, he had an infection of the right foot ulcer and was receiving the following IV antibiotics: 2/15/15 [MEDICATION NAME] in D5W (5% [MEDICATION NAME] (sugar) in water) solution 500 mg/100ml one time a day until 2/28/15 for right foot ulcer infection; 2/15/15 [MEDICATION NAME] HCL Solution 500 mg two times a day until 2/28/15; 2/20/15 [MEDICATION NAME] HCL Solution 1 gm (1000 mg) two times a day for right foot ulcer infection until 2/28/15 (was increased from the 500 mg dose); [MEDICATION NAME]-Tazobactam in [MEDICATION NAME]
solution 3.375 gm/50ml every 6 hours for right foot ulcer infection until 2/28/15.
A review of the medication administration record for February 2015 revealed the [MEDICATION NAME]-Tazobactam was not given on:
2/15/15 at 6 p.m., 2/16/15 at 12 p.m., 2/17/15 at 12 p.m., 6 p.m., 2/19/15 at 6 p.m., 2/21/15 at 6 p.m., and 2/26/15 at 6 p.m.
The [MEDICATION NAME] 500 mg was not given on 2/16 and 2/17 at 12 p.m.
A review of the medication administration record (MAR) for March 2015 revealed the [MEDICATION NAME] 1000 mg every 8 hours
(three times a day) was started on:3/3/15 to 3/11/15, then continued from 3/11/15 until 3/22/15. The [MEDICATION NAME] was not given on:
3/1/15 at 10 p.m., 3/2/15 at 10 p.m., 3/5/15 at 2 p.m. and 10 p.m., 3/6/15 at 6 a.m., 3/8/15 and 3/9/15 at 6 a.m., 10 p.m., 3/10/15 at 10 p.m., 3/11/15 at 6 a.m., 3/13/15 at 10 p.m., 3/14/15 at 6 a.m. 2 p.m., 10 p.m., 3/15/15 at 2 p.m., 10 p.m., 3/16/15 at 10p.m., 3/18/15 at 10 p.m., 3/19/15 at 10 p.m., 3/20/15 at 2 p.m. 10 p.m., and 3/21/15 at 6 a.m., 2 p.m., 10 p.m., 3/22/15 at 6 a.m., 2 p.m., and 10 p.m.
The following IV medications were documented on the MAR as being administer by LVNs:
LVN 20: Levofloxicin on 2/27/15 at 9:14 a.m.; [MEDICATION NAME] 1000 mg on 2/27/15 at 1:48 p.m.; Pipercillian-Tazobactam 3.75 gm on 2/27/15 at 12:03 p.m.
LVN 21: [MEDICATION NAME] 500 mg on 2/18/15 at 6:10 a.m.; 2/19/15 at 5:08 a.m., [MEDICATION NAME] 1000 mg/200 ml, on 2/24/15
at 4:24 a.m.; 4/25/15 at 3:32 a.m.; 3/15/15 at 7:28 a.m., 3/20/15 at 5:05 a.m.;
[MEDICATION NAME]-Tazobactam 3.75 gm on 2/18/15 at 6:10 a.m. and 6:12 a.m. (for midnight and 6 a.m. doses), 2/19/15 at 5:08 a.m. and 5:08 a.m. (for midnight and 6 a.m. doses), 2/24/15 at 4:24 a.m. and 6:19 a.m. (for midnight and 6 a.m. doses), 2/25/15 at 3:32 a.m. and 5:36 a.m. (for midnight and 6 a.m. doses).
LVN 22: [MEDICATION NAME] 500 mg on 2/15/15 at 12 p.m.; [MEDICATION NAME] 1000 mg, on 2/24/15 at 2:26 p.m.
LVN 23: [MEDICATION NAME] 1000 mg on 3/16/15 at 2:29 p.m.
LVN 2: [MEDICATION NAME] 1000 mg on 3/6/15 at 2:33 p.m.
(California Business and Professions Code 2860.5. A licensed vocational nurse when directed by a physician and surgeon may do all of the following:: (c) Start and superimpose intravenous fluids if all of the following additional conditions exist: (1) The nurse has satisfactorily completed a prescribed course of instruction approved by the board or has demonstrated competence to the satisfaction of the board. (2) The procedure is performed in an organized health care system in accordance with the written standardized procedures adopted by the organized health care system as formulated by a committee which includes representatives of the medical, nursing, and administrative staffs. Organized health care system, as used in this section, includes facilities licensed pursuant to Section 1250 of the Health and Safety Code, clinics, home health agencies, physician's offices, and public or community health services. Standardized procedures so adopted will be reproduced in writing and made available to total medical and nursing staffs.)

2. Review of the clinical record, on 5/4/15 at 1:30 p.m., showed Resident 7 was admitted to the facility with multiple medical [DIAGNOSES REDACTED].) Resident 7 had a physician's orders [REDACTED].
During an observation, record review and concurrent interview, on 5/21/15 at 11 am, the MAR (medication administration record) indicated that Resident 7 was not given the 9 am dose of [MEDICATION NAME]. NC (nurse consultant) 2 stated it was not given because there was no RN (registered nurse) available to give the medication. At 11:15 a.m., RN18 entered Resident 7's room and began preparations to administer the [MEDICATION NAME]. RN18 stated she was told to report to work for 11 am.

F 0431

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Many

Maintain drug records and properly mark/label drugs and other similar products according to accepted professional standards.

Based on observation, interview and record review, facility failed to maintain a system for accurately reconciling controlled medications for 4 additionally sampled residents (38, 39, 31, 40), and a record of receipt for medications that arrive in the facility from the pharmacy which resulted in the facility not having accountablility for medication delivered and administered to the residents.
Findings:
1. During an observation of how controlled drugs are stored for destruction, on 5/6/15 at 2:45 p.m. the DON opened a locked file cabinet drawer in her office and the following was noted:
a. One bottle of liquid morphine which contained 14 ml out of a possible 45 ml, with the prescription label torn off that would have included the prescribed residents name. There was Controlled Drug Record with the drug or in the cabinet.
b. One bottle of liquid morphine 30 ml for resident 38 and the Controlled Drug Record sheet revealed 60 ml, leaving 30 ml unaccounted for.
c. One bottle of liquid morphine which contained 5 ml for resident 39 and there was no Controlled Drug Record sheet with recorded dates and times of medication administration to account for the missing 25 ml.
The DON stated that the controlled drugs for destruction were in the locked file cabinet drawer when she became the DON (over a month ago). She was going to destroy them last month but the Pharmacy Consultant was on vacation and his replacement consultant told the DON to wait until the Pharmacy Consultant returned the next month.
2. On 5/6/15 at 3:15 p.m. an observation of the controlled drug reconciliation between the day shift RN (RN 4) and the p.m. shift RN (RN 18) revealed the following: Resident 31 had a bottle of Ativan (a controlled anti-anxiety drug) 0.5mg. The nurses did not know how to count the pills because the pills are small and they didn't have a tray to place the pills on to count them. The Controlled Drug Record reflected that there were 63 pills in the bottle. The RN 18 placed the ativan pills on a tissue and during the count one tablet fell on the ground and was eliminated from the bottle. The count turned up 58 pills and add the one pill that was eliminated that was a total of 59 pills out of 63 pills accounted for on the Controlled Drug Record.
In an interview on 5/7/15 at 7:46 a.m. LVN 21 stated that he did the reconcilliation of controlled drugs with RN 4 between the night and day shift on 5/6/15 with RN 4 but he wasn't looking at the what RN 4 as she counted because he was charting.
3. On 5/21/15 at 7:30 a.m. an observation of the controlled drug reconciliation between the night shift RN (RN 25) and the day shift LVN (LVN 16) revealed that Resident 40 had 25 tablets of Hydrocodone 5/325 mg (narcotic pain medication)

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0431 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 8) remaining in the punch card container, but the Controlled Drug Record dated 3/24/15 the last dose given was on 5/20/15 at 5:10 p.m. and reflected 26 as the amount remaining. A review of the facility's Pharmacy Services and Procedures Manual dated 1/1/13 reflected, .Facility should ensure that the incoming and outgoing nurses count all Schedule II controlled substances and other medications with a risk of abuse or diversion at the change of each shift or at least once daily and document the results on the Controlled Substance Count Verification/Shift Count Sheet . The Pharmacy Services and Procedures Manual further directs facility staff to, IMMEDIATELY report suspected theft or loss of controlled substances to their supervisor/manager for appropriate documentation, investigation, and timely follow-up in accordance with Facility policy and Applicable Law . 4. The facility's medication rooms were inspected on 5/6/15 at 2:30 p.m. with California Department of Public Health State Pharmacy Consultant and the facility DON. The D.O.N. was asked to provide the emergency medication sign out log for review. When asked for the pharmacy receipts for the medication replaced in the the emergency locked container, she could not locate the receipt in the facility two nursing station medication rooms. 5. During an interview on 5/4/15 at 2:30 p.m. Resident 14 said, the next day after he was admitted to the facility he was in pain. The nurse told him she did not have his pain medication. He said that he called 911 and had them take him to the acute hospital so he can receive his pain medication. During an interview with on 5/7/15 at 8:30 a.m. LVN 3 was asked for the pharmacy receipt for the arrival of Resident 14's medication on 5/3/15. She was not able to show the receipt . She said, I will call the pharmacy and ask them to fax me over their copy. Review of the facility's Pharmacy policy and procedure on Receiving Pharmacy products and services read, Upon delivery by Pharmacy, Facility nurse or other authorized designee on behalf of facility should: Sign the delivery manifest, note the time of arrival. Copies of manifest or packing slips may be retained for reference for a period.
F 0441 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Have a program that investigates, controls and keeps infection from spreading.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to establish and maintain an Infection Control Program to provide a safe and sanitary environment and to help prevent the development and transmission of disease and infection affecting one of 19 sampled residents (Resident 9) who had an intestinal infection due to Clostridium difficile with active diarrhea. (Clostridium difficile, also known as C.diff, is a germ that can cause watery diarrhea, fever, loss of appetite. [DIAGNOSES REDACTED] spores can live outside the human body for a very long time (as long as 5 months) and may be found on things in the environment such as bed linens, bed rails, bathroom fixtures, and medical equipment. C.diff infection can spread from person-to-person on contaminated equipment and on the hands of doctors, nurses, other healthcare providers and visitors. (Centers for Disease Control and Prevention - CDC Frequently Asked Questions (FAQ)). Resident 9 was identified during the survey as having an active[DIAGNOSES REDACTED]. infection beginning on 4/8/15. The facility did not have surveillance records for infections in March or May, 2015 and Resident 9 was the only identified infection in April 2015. The facility also failed to prevent the spread of infection by not implementing their policies and procedures for handling the soiled linen, housekeeping and meal delivery for a resident (9) with active C.Diff. The facility licensed nurses failed to follow policies and procedures for dressing changes when the DSD and LVN 13 did not wear gloves while setting up the treatment supplies for two (7,11) residents in a sample of 19. These failures resulted in the potential to spread C.-Diff, a hardy bacteria which can cause a debilitating illness which could result in hospitalization or even death, among the residents with multiple medical problems. The Regional Administrator (RAdmin) was notified of an immediate jeopardy on 5/4/15 at 10:40 a.m. The facility's staff lack of awareness of infected individuals, and lack of an infection control program with an appointed coordinator to monitor, control and prevent the spread of infection was a threat to the health of the individuals living and working in the facility. The DON nor any other nursing staff had any knowledge of the numbers of infected residents in the facility at the time of the survey. One resident (9) was identified as having C.Diff. and had been moved to a single room from a three bed room two weeks ago. The facility records however, reflect Resident 9 had[DIAGNOSES REDACTED]. since February 2015. The CNAs, Laundry worker, Housekeeping, and Dietary departments were not notified and the contaminated linens were sent with the regular laundry, the meal trays sent to Resident 9 were commingled with the other dirty trays after she ate, and the housekeeper was not clear on the housekeeping procedures to prevent the spread of infection from Resident 9's room to the rest of the facility. During the extended survey 5/20/15 and 5/21/15 the immediate jeopardy was lifted and the faciity management including RAdmin were informed on 5/26/15 at 2:45 p.m. The facility obtained infection control professionals to establish a program of surveillance and provide training for the new Director of Staff Development to implement in the facility. Resident 9 was no longer infected with[DIAGNOSES REDACTED]. Findings: 1. The State Agency received complaints (4 and 1) regarding the lack of infection control in the facility and there were unnamed residents infected with C.-Diff who were wandering around the facility. Additionally, the staff weren't washing their hands when necessary, wearing gloves in the hallway, and not changing gloves between residents. During the initial tour of the facility on 5/4/15 at 8:20 a.m. Resident 9's room had a plastic container with gloves, paper gowns and face masks hanging over the door inside the room. There was a sign on the door to see nurses before entering room. LVN 3 stated at 8:46 a.m. that Resident 9 had C.-Diff and was moved from Station 2. She said that the staff should wear a gown, gloves and wash hands when going in and out, and everything stays in the room. On 5/4/15 at 8:20 a.m. observed one trash container in the room, but no container for soiled linen. In an interview with CNA 12 at 8:46 a.m. she stated that she would put Resident 9's soiled linen in a clear plastic bag and place it in the linen barrel in the hallway with the other resident's soiled linen. During an observation and interview in the laundry room on 5/4/15 at 9:15 with the Laundry worker, put on a mask and apron and gloves. She put linens from a barrel into the washing machine, added detergent and then turned on the machine. She then took of her gloves and apron off and washed her hands. She stated that if a resident has C.-Diff. the linen should be in a red bag and washed separately. She also stated that she was unaware of any resident having C.-Diff. in the facility. In an interview with the Janitor who was outside Resident 9's room at 9:45 a.m. he said that he did not know what the infection was in the room but remembered when another resident had a similar sign and set up and he would rear gloves and gown and disinfect everything and the walls. He didn't know if the resident had diarrhea. During a kitchen observation on 5/5/15 at 7:30 a.m. the cook stated that she had not heard of C.-Diff and never heard about it before. She was unaware of any residents that currently had an infection and unaware of the facility's policy and procedure for handling linen of[DIAGNOSES REDACTED] infected residents. A review of the facility's undated Laundry policy and procedure for C.Diff, reflected, .Be sure that all soiled linens containers on the floor are lined with red biohazard bags (to identify any linen that may have contacted c.Diff) .Any surfaces that come in contact with the contaminated laundry should be wiped down with bleach .then disinfected .Be sure to wipe down the rim of the washer as well as the handle and the control panel . The DSD provided copies of the infection control Surveillance sheets on 5/4/15 which contained data from Jan, Feb and [DATE]. There were four instances of[DIAGNOSES REDACTED] identified. He stated that he had not been trained on infection control and those were to documents left over from the previous DSD. 2. Review of the clinical record, on 5/5/15 at 11:30, showed Resident 9 was admitted to the facility on [DATE] with multiple diagnoses. The document titled, Surveillance Data Collection Form, dated 4/12/15, indicated Resident 9 was hospitalized from [DATE] through 4/7/15 and readmitted to the facility on [DATE] with an onset of [DIAGNOSES REDACTED] on 4/8/15. During an observation and concurrent interview, on 5/6/15 at 8:10 a.m., CNA (certified nurse assistant) 14 carried a food tray into Resident 9's room. The tray was placed on Resident 9's over bed tray which had spills on top. The tray held food

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F 0441

Level of harm - Immediate jeopardy

Residents Affected - Many

(continued... from page 9)
placed in disposable containers and disposable eating utensils. The plate of food was covered with a plastic food cover. When CNA 14 had finished feeding the resident, she stated, I don't know where we're supposed to throw the food. They just started this disposable stuff since you guys came. Usually we just put it on the cart with the other trays. CNA14 dumped the disposable containers and utensils and the leftover food in the trash container located in the room. CNA14 took the tray and food cover out of the room and placed them on a three tier cart sitting in the hallway. The top tier of the cart held three large carafes, two were labeled coffee and one was labeled hot water. The tray and food cover were placed on the second tier of the cart.
During an interview, on 5/6/15 at 8:25 a.m., the DA (dietary aide) stated food trays were not allowed in Resident 9's room. The CNAs were to remove the food from the tray, leave the tray outside of the room and carry the food in the disposable containers into the room. When done, the disposable items were to be discarded in the trash container in the resident's room. The DA stated this information had been discussed with the charge nurses.
During an interview, on 5/6/15 at 8:42 a.m., LVN (licensed vocational nurse) 2 stated the CNAs working with Resident 9, including CNA14, had been told to take disposable plates and utensils into Resident 9's room and leave the tray outside of the room.
In an interview, on 5/6/15 at 8:40 a.m., the DSD stated LVN2 had been trained yesterday after a meeting in which someone mentioned it would be good to start using disposable plates and utensils in the infected rooms and leave the tray outside of the room.
(re: Complaint 4 and 1)
3. Review of the clinical record, on 5/4/15 at 1:30 p.m., showed Resident 7 was admitted to the facility with multiple medical [DIAGNOSES REDACTED].)
During an observation and concurrent interview, on 5/4/15 at 2:46 p.m., LVN (licensed vocational nurse) 13 prepared to do Resident 7's dressing change for a pressure ulcer of the sacrum (lower back). LVN13 placed three plastic containers onto the top of the treatment cart, which was sitting in the hall outside of the resident's room. LVN13 poured normal saline (salt water solution) into 2 of the plastic cups, put on a pair of non-sterile gloves and placed gauze into the third cup. LVN 13 took the cups, an unopened package of packing strips and an unopened drape package into Resident 7's room and placed them on the soiled over bed table. LVN removed the gloves and spread the drape on the over bed table, and moved the containers and packing strips from the table onto the drape. When asked if LVN13 was using a clean technique (free from dirt) or sterile technique (free from organisms) for the dressing change, she stated, Sterile. Clean technique I would have used a bleach towelette, wiped it down to make sure the counter top was clean.
Review of the facility's policy and procedure titled, Dressings- Application with a revision date of 1/01/12 under Application of Sterile Dressings (Clean Technique) read, Set up non-sterile moisture barrier drape on over-bed tale only. Bring all dressings, solutions and items to be used and place on on-sterile drape.
(re: Complaint 9)

4. During the initial observation of the facility on 5/4/15 at 11:00 a.m. the maintenance supervisor had the maintenance cart in Resident 9's bathroom.
During an interview with the maintenance supervisor on 5/4/15 at 11:15 a.m. he stated , I'm changing the light bulb. I did not have an inservice. I couldn't tell you what precautions to take for C Diff.
5. On 5/5/15 at 2:30 p.m. the surveyor observed the DSD prepare to do the treatment to Resident 11's stage three (Full thickness tissue loss. Subcutaneous (under the skin) fat may be visible) pressure sore on her right shin.
The DSD removed some gauze from one package and opened up another package and removed a self adhesive dressing without wearing gloves. He then put gloves on went into Resident 11's room and after removing the old dressing washing his hands and putting new gloves on he cleansed the pressure sore to her right shin with the gauze and covered it with the adhesive dressing.
Review of the facility's policy and procedure for dressings application revised on 1/ 1/12 read under purpose, To ensure cleanliness and prevent infection by protecting the skin's surface and to promote comfort and wound healing. Under procedure read, Wash hands before and after each procedure and put on gloves.
During an interview with the DSD on 5/6/15 at 8:15 a.m. he stated, I didn't receive any formal training on wounds. The previous treatment nurse just gave me a run down on how she was doing the treatments. I just started doing the treatment from memory. This was my first job as a licensed nurse. I've only been a nurse for ten months.
(re: Complaint 9)