State of California - Health and Human Services Agency

Department of Public Health

SECTION 1424 NOTICE

CITATION NUMBER: 11-2584-0012467-F

Date: 08/16/2016 Time: 3:00PM

Type of Visit : Complaint Investig.

YOU ARE HEREBY FOUND IN VIOLATION OF APPLICABLE CALIFORNIA STATUTES AND REGULATIONS OR APPLICABLE FEDERAL STATUTES AND REGULATIONS

Incident/Complaint No.(s) : CA00468724

Licensee Name: Seaview Rehabilitation & Wellness Center, LP

Address: 6400 Purdue Drive Eureka, CA 95503

License Number: 010000066 Type of Ownership: Partnership

Facility Name: Seaview Rehabilitation & Wellness Center, LP

Address: 6400 Purdue Dr Eureka, CA 95503

Telephone:

Facility Type: Skilled Nursing Facility Capacity: 99

Facility ID: 010000060

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS	PENALTY ASSESSMENT $20,000.00	DEADLINE FOR COMPLIANCE 9/1/16 6:00 a.m.

F314

CLASS A **CITATION -- PATIENT CARE**

F314 §483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

The facility failed to provide Resident 1 the necessary care and services for the prevention of an avoidable pressure ulcer when the facility failed to implement strategies that minimize the risk for pressure ulcer development and not identifying the use of pressure-redistributing equipment in the care planning of Resident 1's identified risk for developing pressure ulcers. These failures resulted in harm to Resident 1 when he developed a stage 4 pressure ulcer (full thickness skin loss with extensive destruction, tissue necrosis (the death of tissue or damage to muscle, bone or supporting structures due to disease, injury, or failure of the blood supply). The pressure ulcer became infected and the infection spread to Resident 1's blood stream (sepsis). The results of the facility's failures caused Resident 1 pain, presented the potential for death, and required hospitalization, prolonged intravenous antibiotic therapy and surgical interventions to treat the infected pressure ulcer.

Name of Evaluator: Lourdes Sameon HFEN

Lourdes Sameon HFEN

Evaluator Signature : Lourdes Sameon HFEN

Without admitting guilt, I hereby acknowledge receipt of this SECTION 1424 NOTICE

Signature : Lorena A. Smith, LNHA

Name : Lorena A. Smith, LNHA

Title : Administrator

NOTE: IN ACCORDANCE WITH CALIFORNIA HEALTH AND SAFTEY CODE, FAILURE TO CORRECT VIOLATIONS IS GROUNDS FOR SUSPENSION OR REVOCATION OF YOUR LICENSE

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS

Findings:

Resident 1 was admitted from an acute hospital for aortic valve replacement (aortic valve replacement is a procedure in which a patient's failing aortic valve is replaced with an artificial heart valve) to the facility, a full code (it is a hospital designation referring to the level of medical interventions a patient wishes to have started if the heart or breathing stops) on 11/18/15, with diagnoses that included abnormalities of gait and mobility, aortic stenosis,(Blood from the heart is pumped through the aortic valve. A narrow aortic valve limits the circulation of oxygenated blood to the rest of your body), diabetes mellitus (a medical condition in which sugar levels can build up in your bloodstream), delirium (a severe disturbed state of mind that occurs in fever, intoxication, and characterized by restlessness, delusions, and incoherence of thought and speech).

Review of Resident 1's acute hospital Transfer Summary, dated 11/18/15, under "Skin Condition," indicated no pressure areas/ulcers.

Review of Resident 1's Admission Assessment, dated 11/18/15, indicated Resident 1's skin was pink, dry/flaking, fair in turgor (the degree of elasticity of skin) and warm. No pressure ulcer was identified.

Review of the Braden Scale for predicting Pressure Sore Risk dated 11/19/15, indicated Resident 1 scored 13 indicating moderate risk (total score less than 9 indicate severe risk).

With regard to long term care (LTC) residents, calculating a Braden Scale score on admission, every week for 4 weeks, and then again either monthly or quarterly is suggested. (References: National Pressure Ulcer Advisory Panel (NPUAP) pressure ulcer stages/categories).

Review of the MDS (Minimum Data Set, a Resident assessment tool), dated 11/25/15, indicated Resident 1 had a cognitive score of 0 indicating severe impairment (0-7 severe impairment; 13-15 cognitively intact; 8-12 moderately impaired), had short and long-term memory problems, needed extensive assistance of one person physical assist for bed mobility, transfers, dressing, and toileting. Additionally, the MDS indicated Resident 1 was always incontinent of bladder and bowel, had a nutritional risk and was at risk of developing pressure ulcers.

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	Review of Resident 1's "Care Plan Incontinence," dated 11/19/15, indicated interventions, among others, to provide incontinence care after each incontinent episode and to observe skin for any abnormalities during toileting and/or changing. During an interview on 12/30/15 at 9 a.m., Unlicensed Staff A, working a morning shift on 12/2/15, stated he observed an open area without a dressing on Resident 1's right buttock. Unlicensed Staff A reported to License Nurse E. During an interview on 12/30/15 at 10:55 a.m., the DON stated Resident 1 was at a high risk for developing skin breakdown due to Resident 1's diagnoses of diabetes mellitus, Wernicke's encepalopathy (a serious neurologic disorder from Thiamine (vitamin B-1) deficiency), and delirium (Delirium is a serious disturbance in mental abilities that results in confused thinking starting in hours or a few days). During an interview on 12/30/15 at 12:02 p.m., when asked how Resident 1 spent his day Licensed Staff B stated, "He spends most of his day in the wheelchair and is taken back to bed after lunch. The evening staff would get him up and take him back to bed after dinner." Residents may experience more rapid skin breakdown while sitting for prolonged periods in a chair, as the ability to distribute pressure over the pelvis is more limited than when they are lying in a bed. (References: National Pressure Ulcer Advisory Panel (NPUAP) pressure ulcer stages/categories). Review of Resident 1's " Care Plan Skin" dated 11/18/15, did not include pressure redistributing devices for chair and bed (provides alternating pressure and is designed to be used in the prevention, treatment and management of pressure ulcers), indicated to turn and reposition, monitor for signs and symptoms of infection." During a telephone interview on 2/16/16 at 4:50 p.m., Licensed Staff C, working on an evening shift, stated he first knew of Resident 1's open area on the buttock on 12/5/15. When asked what he saw, Licensed Staff C stated, "I saw a sore on Resident 1's bottom. It looked like a popped blister; it was without skin (looking raw without the protective skin covering)." Licensed Staff C also stated he did not measure and document the open area but passed on the information to the night nurse. Review of Nurse's Notes, dated 12/5/15 at 12:30 p.m., indicated Resident 1 did not get out of bed for lunch, still feeling drowsy, increased jerking in hands and arms and felt

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS

warm to touch. Resident 1's axillary (underarm) temperature was 99.1 (Normal body temperature is considered to be 98.6 F).

Nurse's Note entry 12/6/15, a.m., indicated temperature 101. On 12/7/15 at 11:50 a.m., increased tremors were noted, and Resident 1's temperature was 102.

Resident 1 required hospitalization on 12/08/16, for evaluation and treatment.

Review of the acute hospital's Admission Report dated 12/9/15 indicated Resident 1 being febrile (temperature of 101.8) and increasingly altered level of consciousness and a right buttock decubitus (a pressure ulcer, pressure sore, or bed sore, is an open wound on the skin) into the fascia (a thin sheath of fibrous tissue enclosing a muscle or organ).

Review of the acute hospital's Progress Note, dated 12/10/15, indicated a right coccyx (tailbone)/sacrum (a large, triangular bone at the base of the spine)/ischial (as a pair the sitting bones) ulcer with periulcer erythema (surrounding redness of the wound) measuring 6.52 cm (centimeter is a unit of length in the metric system,1 inch =2.54 cm) in diameter (width) and 6.14 cm in length, 100% non-viable (dead tissue) wound bed, requiring excisional debridement (the surgical removal or cutting away of necrotic or devitalized tissue. Healing time: Anywhere from three months to two years.) of necrotic tissue (dead tissue, which usually results from an inadequate local blood supply).

Review of the acute hospital Discharge Summary, dated 1/21/16, indicated discharge diagnoses: Sacral decubitus stage 4 (the wound extends into the muscle and can extend as far down as the bone) and Sepsis with MRSA. Blood culture and wound culture were both positive for MRSA, on admission, as indicated on the Hospitalist Progress Note, dated 1/13/16 at 1315 (1:15 p.m.).

Review of facility document titled, "Skin and Wound Management," indicated under Policy: "Facility Staff will take appropriate measures to prevent and reduce the likelihood that residents will develop pressure ulcers and other skin conditions. All Nursing Staff is responsible for the prompt reporting of any sin related conditions to the Licensed Nurse. The License Nurse will notify the Attending Physician promptly at the first occurrence of a pressure ulcer or other skin related problems." Under Procedure 11. Skin and Wound Management: A. A Licensed Nurse will complete the Weekly Skin Evaluation (SK-04 -Form C- Weekly Skin Evaluation) for each resident...B. CNAs (certified nurse assistants) will complete body checks on resident's shower days and

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	report unusual findings to the Licensed Nurse. Therefore, the facility failed to provide the necessary care and services to prevent an avoidable Stage 4 pressure ulcer, by withholding interventions that could have prevented the formation of the pressure ulcer which became infected with multiple bacterial and fungal, life-threatening organisms which resulted in pain and sepsis which required hospitalization, surgery and prolonged antibiotic treatments. This presented either imminent danger that death or serious harm would result or a substantial probability that death or serious harm would result.

State of California - Health and Human Services Agency | Department of Public Health

CIVIL MONEY PENALTY ASSESSMENT

Facility : Seaview Rehabilitation & Wellness Center, LP

DATE	CITATION #	CLASS	PENALTY ASSESSED	TOTAL DUE
08/16/2016	11-2584-0012467-F	A	$20,000.00	$20,000.00
SECTION(S) VIOLATED				
F314				

This citation has been issued as a Class A.

Full Payment Due By : 10/15/2016

PAYMENT OPTIONS

Per Health and Safety Code, Section 1428.1, licensee may pay 65% of the amount shown above in the "Total Due" within 30 business days after issuance of this citation, or the minimum amount defined by law, whichever is greater in lieu of contesting the citation (Class A Citation penalty minimum amount defined by law is $2000). If licensee chooses not to exercise the 65% / 30 business day option, the full amount is due.

Make Check Payable To:
Department of Public Health
Include Citation Number

Mailing Address:
Licensing and Certification Program
Grant & Fiscal Assessment Unit
P.O. Box 997434, MS 3202
Sacramento, CA 95899-7434
(916) 322-2118

COLLECTION OF DELINQUENT PAYMENTS

CDPH will pursue collection of delinquent payments, including, but not limited to Medi-Cal offset (per Health & Safety Code, Section 1428). This will result in withholding of the licensee's Medi-Cal payments until the full amount of the citation is collected. In order to present a valid objection to the use of Medi-Cal offset, please contact the Grant and Fiscal Assessment Unit at the address listed above.

CONTESTING A CLASS A CITATION

A licensee may contest a class "A" citation or penalty assessment by directly filing an action in Superior Court. (Health and Safety Code Section 1428.)

To contest a class "A" citation or penalty assessment, a licensee must send written notification to the Department advising of its intent to adjudicate the validity of the citation in court. (Health and Safecty Code Section 1428.)

Please note, effective January 1, 2012, Assembly Bill No. 641 (Chapter 729, Statutes of 2011) amended Health and Safety Code Section 1428 to repeal the citation review conference process for "A" citations issued on or after January 1, 2012. Therefore, if a licensee exercised its right to a citation review conference prior to January 1, 2012, the citation review conference and all notices, reviews, and appeals thereof shall be conducted pursuant to Section 1428 as it read on December 31, 2011.

The citation review conference process is no longer available to a licensee for citations issued on or after January 1, 2012.

Any written notification must be sent to the district office that issued the citation and must be postmarked within fifteen (15) business days after the service of the citation. Please submit written notification to:

Department of Public Health
Licensing & Certification Program
Santa Rosa/Redwood Coast District Office
2170 Northpoint Parkway
Santa Rosa, CA 95407

Signature of District Manager/Designee

8/16/16
Date

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055208	A. BUILDING ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seaview Rehabilitation & Wellness Center, LP	6400 Purdue Dr, Eureka, CA 95503-7095 HUMBOLDT COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
	The following reflects the findings of the Department of Public Health during a Complaint Investigation visit: CLASS A CITATION -- PATIENT CARE 11-2584-0012467-F Complaint(s): CA00468724 Representing the Department of Public Health: Surveyor ID # 31572, HFEN The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. F314 §483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. The facility failed to provide Resident 1 the necessary care and services for the prevention of an avoidable pressure ulcer when the facility failed to implement strategies that minimize the risk for pressure ulcer development and not identifying the use of pressure-redistributing equipment in the care planning of Resident 1's identified risk for developing pressure ulcers. These failures resulted		"Preparation and submission/or execution of the Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared, submitted and/or executed solely because it is required by the provision of federal and state law." F314 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES **Corrective action for the identified resident(s)** Resident 1 has been discharge from the facility. However, the DON (Director of Nursing) /DSD (Director of Staff Development) will discuss on 7/21/16 and 7/29/16 with licensed nurse's the importance of providing necessary care and services in a timely manner. **How the facility will identify residents with the potential to be affected:**	8/16/16

Event ID:95ZV11 8/15/2016 9:11:24AM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ladena A. Smith, LNHA
TITLE: Administrator
(X6) DATE: 8/16/16

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 7

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. Except for nursing homes, the findings 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.

Approved POC from Administrator Ladena Smith by Lourdes Ronleon HFEN on 8/3/16 and by [illegible] 8/16/16

State-2567

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	in harm to Resident 1 when he developed a stage 4 pressure ulcer (full thickness skin loss with extensive destruction, tissue necrosis (the death of tissue or damage to muscle, bone or supporting structures due to disease, injury, or failure of the blood supply). The pressure ulcer became infected and the infection spread to Resident 1's blood stream (sepsis). The results of the facility's failures caused Resident 1 pain, presented the potential for death, and required hospitalization, prolonged intravenous antibiotic therapy and surgical interventions to treat the infected pressure ulcer. Findings: Resident 1 was admitted from an acute hospital for aortic valve replacement (aortic valve replacement is a procedure in which a patient's failing aortic valve is replaced with an artificial heart valve) to the facility, a full code (it is a hospital designation referring to the level of medical interventions a patient wishes to have started if the heart or breathing stops) on 11/18/15, with diagnoses that included abnormalities of gait and mobility, aortic stenosis,(Blood from the heart is pumped through the aortic valve. A narrow aortic valve limits the circulation of oxygenated blood to the rest of your body), diabetes mellitus (a medical condition in which sugar levels can build up in your bloodstream), delirium (a severe disturbed state of mind that occurs in fever, intoxication, and characterized by restlessness, delusions, and incoherence of thought and speech). Review of Resident 1's acute hospital Transfer		Residents identified with significant changes of status on admission and throughout stay who have risk factors such as vital sign changes, signs and symptoms of infection/sepsis recent surgeries, circulatory/vascular conditions risk of weight loss, incontinence, history of skin variances, non compliant behaviors, cognitive impairment and those identified high risk on the Braden Assessment have the potential to be affected. **Systemic changes:** During admission, resident's will be assessed by the licensed nurse assigned to the resident with the Braden Assessment tool to predict pressure injury risk to include sensory perception, moisture, degree of activity and mobility, nutrition, friction and shearing. A skin care plan will be implemented and/or revised and updated to reflect nursing intervention to minimize risk. In addition, residents with a change of condition status such as weight variances, incontinence, cognitive impairment, circulatory and vascular problems, with history and current skin variances will be	**8/16/16**

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	Summary, dated 11/18/15, under "Skin Condition," indicated no pressure areas/ulcers. Review of Resident 1's Admission Assessment, dated 11/18/15, indicated Resident 1's skin was pink, dry/flaking, fair in turgor (the degree of elasticity of skin) and warm. No pressure ulcer was identified. Review of the Braden Scale for predicting Pressure Sore Risk dated 11/19/15, indicated Resident 1 scored 13 indicating moderate risk (total score less than 9 indicate severe risk). With regard to long term care (LTC) residents, calculating a Braden Scale score on admission, every week for 4 weeks, and then again either monthly or quarterly is suggested. (References: National Pressure Ulcer Advisory Panel (NPUAP) pressure ulcer stages/categories). Review of the MDS (Minimum Data Set, a Resident assessment tool), dated 11/25/15, indicated Resident 1 had a cognitive score of 0 indicating severe impairment (0-7 severe impairment; 13-15 cognitively intact; 8-12 moderately impaired), had short and long-term memory problems, needed extensive assistance of one person physical assist for bed mobility, transfers, dressing, and toileting. Additionally, the MDS indicated Resident 1 was always incontinent of bladder and bowel, had a nutritional risk and was at risk of developing pressure ulcers. Review of Resident 1's "Care Plan Incontinence,"		provided observation, monitoring, nursing intervention and documentation of such will be made by the licensed nurse assigned to the resident. This review will be made timely with MD, responsible party and resident notifying of any significant changes. Licensed nurses/DSD will observe and monitor the C N A's to assure the provision of preventive skin care measures are in place and provide guidance and teaching for special residents at risk when indicated. The charge nurse will make random rounds through out their shift for proper positioning and turning and preventative skin and incontinence care. Bath day skin reviews will be made though out the week by the C N A's and will be reviewed by the nurse on assigned shift. Interventions and follow up will be provided to include notification of MD and responsible party/resident of new and/ or changed skin variances. The resident nurse's notes will reflect the actions taken for those residents who have a change of condition with skin status. The licensed nurse will be expected to seek timely additional support and direction will be asked	8/16/16

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	dated 11/19/15, indicated interventions, among others, to provide incontinence care after each incontinent episode and to observe skin for any abnormalities during toileting and/or changing. During an interview on 12/30/15 at 9 a.m., Unlicensed Staff A, working a morning shift on 12/2/15, stated he observed an open area without a dressing on Resident 1's right buttock. Unlicensed Staff A reported to License Nurse E. During an interview on 12/30/15 at 10:55 a.m., the DON stated Resident 1 was at a high risk for developing skin breakdown due to Resident 1's diagnoses of diabetes mellitus, Wernicke's encepalopathy (a serious neurologic disorder from Thiamine (vitamin B-1) deficiency), and delirium (Delirium is a serious disturbance in mental abilities that results in confused thinking starting in hours or a few days). During an interview on 12/30/15 at 12:02 p.m., when asked how Resident 1 spent his day Licensed Staff B stated, "He spends most of his day in the wheelchair and is taken back to bed after lunch. The evening staff would get him up and take him back to bed after dinner." Residents may experience more rapid skin breakdown while sitting for prolonged periods in a chair, as the ability to distribute pressure over the pelvis is more limited than when they are lying in a bed. (References: National Pressure Ulcer Advisory Panel (NPUAP) pressure ulcer stages/categories).		for by the licensed nurse from the DON and or DSD to support appropriate care and services. Entry into the 24 change of condition binder will be made by the nurse to assure follow up by the clinical IDT occurs on each shift. The Stop and Watch tool will be encouraged and reinforced to the C. N .A's to use and validate their observations of potential changes in residents ADL and skin during their shift.. The Stop and Watch form will be reviewed by the charge nurse and followed up accordingly. The Stop and Watch form will be added to the 24 hour report book for follow up by the clinical IDT review team. The Stop and Watch forms are available at each nurse's station for use. • Observation and mentoring of C N A's. Random clinical rounds • Guidelines for follow up with skin variances, pressure injuries • Preventive skin measures and pressure reduction devices. • Change of Condition Management • Prompt notification of MD, family and responsible party	8/16/16

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	Review of Resident 1's " Care Plan Skin" dated 11/18/15, did not include pressure redistributing devices for chair and bed (provides alternating pressure and is designed to be used in the prevention, treatment and management of pressure ulcers), indicated to turn and reposition, monitor for signs and symptoms of infection." During a telephone interview on 2/16/16 at 4:50 p.m., Licensed Staff C, working on an evening shift, stated he first knew of Resident 1's open area on the buttock on 12/5/15. When asked what he saw, Licensed Staff C stated, "I saw a sore on Resident 1's bottom. It looked like a popped blister; it was without skin (looking raw without the protective skin covering)." Licensed Staff C also stated he did not measure and document the open area but passed on the information to the night nurse. Review of Nurse's Notes, dated 12/5/15 at 12:30 p.m., indicated Resident 1 did not get out of bed for lunch, still feeling drowsy, increased jerking in hands and arms and felt warm to touch. Resident 1's axillary (underarm) temperature was 99.1 (Normal body temperature is considered to be 98.6 F). Nurse's Note entry 12/6/15, a.m., indicated temperature 101. On 12/7/15 at 11:50 a.m., increased tremors were noted, and Resident 1's temperature was 102. Resident 1 required hospitalization on 12/08/16, for evaluation and treatment.		• Braden score • Risks for pressure injuries • Use of Stop and Watch, 24 hour report and purpose of skin meetings and referrals. Certified nurse's aides will be in serviced by DSD (Director of Staff Development) on steps to follow regarding the prevention of pressure injuries, timely reporting to the assigned license nurse for the resident of any noted concerns, skin variances, changes in the vital signs, the Stop and Watch Program, and location of the forms and how to proceed during their assigned shift. Nurses will be offered as additional resources to assist with identification of a pressure injury and significant change of condition, such as increased temperature and sepsis and the steps to take. The DON (Director of Nursing) will reinforce and educate on the following resources and provide instruction on the steps for nurses to follow change of condition management and their role.	8/16/16

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	Review of the acute hospital's Admission Report dated 12/9/15 indicated Resident 1 being febrile (temperature of 101.8) and increasingly altered level of consciousness and a right buttock decubitus (a pressure ulcer, pressure sore, or bed sore, is an open wound on the skin) into the fascia (a thin sheath of fibrous tissue enclosing a muscle or organ). Review of the acute hospital's Progress Note, dated 12/10/15, indicated a right coccyx (tailbone)/sacrum (a large, triangular bone at the base of the spine)/ischial (as a pair the sitting bones) ulcer with periulcer erythema (surrounding redness of the wound) measuring 6.52 cm (centimeter is a unit of length in the metric system,1 inch =2.54 cm) in diameter (width) and 6.14 cm in length, 100% non-viable (dead tissue) wound bed, requiring excisional debridement (the surgical removal or cutting away of necrotic or devitalized tissue. Healing time: Anywhere from three months to two years.) of necrotic tissue (dead tissue, which usually results from an inadequate local blood supply). Review of the acute hospital Discharge Summary, dated 1/21/16, indicated discharge diagnoses: Sacral decubitus stage 4 (the wound extends into the muscle and can extend as far down as the bone) and Sepsis with MRSA. Blood culture and wound culture were both positive for MRSA, on admission, as indicated on the Hospitalist Progress Note, dated 1/13/16 at 1315 (1:15 p.m.). Review of facility document titled, "Skin and Wound		• Stop and Watch Program • Change of shift 24 hour report process • MD consultant for wound management • Sbar Tools for communication/ documentation assessment guide • Importance of notification of the resident, family or responsible party, physician timely of changes of condition timely for consult and recommendations for care and or new interventions as indicated. Observation and monitoring of the effectiveness of current treatment and the residents response to that treatment. • Consult with the treatment nurse and or the DSD (Director of Staff Development) and DON (Director of Nursing) for	8/16/16

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Seaview Rehabilitation & Wellness Center, LP	6400 Purdue Dr, Eureka, CA 95503-7095 HUMBOLDT COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
	Management," indicated under Policy: "Facility Staff will take appropriate measures to prevent and reduce the likelihood that residents will develop pressure ulcers and other skin conditions. All Nursing Staff is responsible for the prompt reporting of any sin related conditions to the Licensed Nurse. The License Nurse will notify the Attending Physician promptly at the first occurrence of a pressure ulcer or other skin related problems." Under Procedure 11. Skin and Wound Management: A. A Licensed Nurse will complete the Weekly Skin Evaluation (SK-04 -Form C-Weekly Skin Evaluation) for each resident...B. CNAs (certified nurse assistants) will complete body checks on resident's shower days and report unusual findings to the Licensed Nurse. Therefore, the facility failed to provide the necessary care and services to prevent an avoidable Stage 4 pressure ulcer, by withholding interventions that could have prevented the formation of the pressure ulcer which became infected with multiple bacterial and fungal, life-threatening organisms which resulted in pain and sepsis which required hospitalization, surgery and prolonged antibiotic treatments. This presented either imminent danger that death or serious harm would result or a substantial probability that death or serious harm would result.		support • Referral process to other IDT members and appropriate discipline. • Purpose and referrals to skin meeting. In addition, licensed nurses will be provided training which will include new hired nurses during orientation on the above listed areas with emphasis on: • Pressure relief devices including bed mattress to minimize and redistribute pressure, specialty pressure reducing devices, alternative interventions for prevention of skin breakdown when indicated. • Importance of observing monitoring and making random shift rounds of residents and care provided by C N A's and providing teaching and guidance. **Monitoring Process:**	**8/16/16**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER SUPPLIER CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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			Regular business days stand up clinical review will occur with the DON, Administrator and IDT utilizing the 24 hour resident shift report as a guideline. Identified entries of concern, stop and watch form and incident reports will be used/Evidence of effectiveness of the use of Stop and Watch will be reviewed by the team. The charge nurse assigned to the resident on each shift will provide random clinical rounds on resident identified as high risk such as those who are cognitively impaired, incontinent, new and previous skin variances, change in weight status, changes in vitals signs, signs and symptoms of infection/sepsis and change of condition. The DON, DSD will make daily supervisory skin & care rounds, and random rounds through out the week to follow up on change of condition status and provide support and guidance as indicated to the charge nurse to observe for compliance to care standards of the nurses and C N A.	8/16/16

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			A weekly skin meeting will occur with the DON participating and the RD and discussion of residents with high risk factors, change of condition, new admits, those with new and history of skin variances will be reviewed. The 24 hour clinical report will support new admissions and those requiring review. Referrals and follow up support will be made to the wound MD for support, by recommendations and assessment under the direction of the DON/treatment nurse. Referrals will be made to the registered dietitian, therapy department for support and direction with nutritional and therapy support when indicated. The change of condition review audit tool will be utilized during clinical rounds for residents preventing at risk for skin variances and those with new or existing wounds. Follow up of the audit will be made by the DON as indicated.	8/16/16

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			Licensed nurses will be quizzed by the DON/DSD on their role of understanding and role of the change of condition binder, Sbar tools for support of communication and follow up with change of condition. In addition, nurses responsibility to follow up with the resident, responsible party and physician timely regarding change of condition/skin management, documentation in the 24 hour report and the nurse's notes. On the importance of nurse making random clinical rounds on residents assigned to their care and assure that the C N A s demonstrate appropriate and preventive skin care and/or follow up with teaching and guidance report along with the Stop and Watch Program through out their assigned shifts will be monitored and expected of the license nurse. The DON will supervise throughout the week for compliance. Trends and or concerns identified during Skin Committee Meeting will be shared with the QAA Committee for further suggestions and or recommendation. The Administrator /DON will be responsible for this	**8/16/16**

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			process. **Integrating into quality assurance program:** The effectiveness of the trainings, change of condition, clinical review, skin meeting and the observation monitoring of the C N As attention to the resident and the Stop and Watch Program, and the facility Quality Assurance and Performance Improvement (QAPI) plan, will be discussed by the Administrator and the DON at the monthly Quality Assurance Meeting for the next 3 months and will be extended as deemed necessary by the QAA Committee. **Corrective Action Date: 8/16/16**	**8/16/16**