State of California - Health and Human Services Agency

Department of Public Health

SECTION 1424 NOTICE

CITATION NUMBER: 94-1645-0012660-F

Date: 11/01/2016 Time: 9:22 am

Type of Visit : Complaint Investig.

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

Incident/Complaint No.(s) : CA00494101

Licensee Name: Country Villa South Bay, LLC

Address: 5901 Downey Ave. Long Beach, CA 90805-4518

License Number: 940000082 Type of Ownership: Limited Liability Company

Facility Name: COUNTRY VILLA BELMONT HEIGHTS HEALTHCARE CENTER

Address: 1730 Grand Ave Long Beach, CA 90804

Telephone:

Facility Type: Skilled Nursing Facility Capacity: 117

Facility ID: 940000053

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS	PENALTY ASSESSMENT $16,000.00	DEADLINE FOR COMPLIANCE 11/1/16 12:00 a.m.

F309
F314

received 11-14-16

CLASS A **CITATION -- PATIENT CARE**

§483.25(c)(1-2)
F 314
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.

§483.25
F309
Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

The Department received a complaint on 7/1/16, alleging that a resident (Resident 1) arrived to the acute hospital, requiring a transfer to the intensive care unit (ICU) due to numerous Stage 3-4 pressure wounds on the hips, abdomen, and thigh area. Family expressed concerns regarding lack of care and treatment at the SNF.

Name of Evaluator:
Beverly Ukoha
SR HFEN

Evaluator Signature Jessica Castillo for

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

Signature :

Name : Balsheva Gradin

Title : Admin

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

The facility failed to provide each resident with the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care, and to ensure that a resident who enters the facility without pressure sores does not develop pressure sores; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing, including but not limited to:

1. Failure to accurately assess Resident 1's risk for pressure ulcer development.

2. Failure to implement the facility's policy, dated 1/1/12, and titled, "Pressure Ulcer Prevention."

3. Failure to follow Resident 1's plan of care in pressure sore prevention in turning every two hours and keeping her clean and dry.

4. Failure to identify Resident 1's change in condition, which required an immediate attention, until Resident 1's family member insisted Resident 1 be transferred to the hospital.

These deficient practices resulted in Resident 1 not being identified as a high risk for pressure sores development; developing many Stage III and IV pressure sores; (Stage III =a deep wound, the loss of skin usually exposes some fat; Stage IV a pressure sore that is very deep, reaching into muscle and bone and causing extensive damage) that became infected; becoming unresponsive and requiring an emergency transfer (911) to a general acute care hospital (GACH) on 6/29/16. Resident 1 required an intensive care unit admission, fluid intravenously ([IV] into vein), multiple IV antibiotics and aggressive wound care twice a day, and pain medications. Resident 1 required a 21-day hospital stay for care and treatment of the many infected pressure sores that led to sepsis (a life-threatening condition in which the body is fighting a severe infection that has spread via the bloodstream) and was discharged on 7/19/16.

A review of Resident 1's Admission Face Sheet indicated Resident 1 was a 66 year-old female, who was initially admitted to the facility on 11/10/15, and most recently

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readmitted on 6/1/16. Resident 1's diagnoses included hypertension (high blood pressure), diabetes (high blood sugar) respiratory failure with a tracheostomy (an opening surgically created through the neck into the trachea (windpipe) to allow direct access to the breathing tube) requiring ventilator support (mechanical life support; breathing machine), dysphagia (difficulty swallowing) with a gastrostomy tube ([G-tube] feeding tube surgically placed through the skin and abdominal wall, for the introduction of food and fluids), end stage renal disease ([ESRD] last stage of chronic kidney disease [CKD] and dialysis or transplant is required to stay alive) requiring dialysis treatments (process of removing waste products and excess fluid from the body) three times a week (Monday, Wednesday, and Fridays [MWF]), morbid obesity (too much body fat for your height; is when the excess body fat becomes a danger to ones' overall health)..

A review of Resident 1's skin assessment upon admission, dated 11/10/15, indicated Resident 1 had redness to the perineal area (between the vulva [external genital organs] and anus [rectum]) and surrounding the G-Tube area was a hard mass (a lump that can be within the skin, in the tissues, under the skin or attached to the skin and/or underlying tissues) to the lower abdominal fold area with no pain.

A review of Resident 1's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 12/30/15, indicated Resident 1 was alert and oriented to person, place, and time as evidenced by the brief interview of mental status (BIMs) with a score of 15 (score of 8 to15=inter-viewable). The MDS, under Section G, Functional Status, indicated Resident 1 was totally dependent on staff requiring a two+ physical assist for turning in bed and of any slight position changes, movement on and off the unit, dressing, eating, toilet use, and personal hygiene, with the exception of eating, Resident 1 required a one-person physical assist. According to the MDS, Resident 1 was non-ambulatory and incontinent (unable to control) of bowel and bladder.

On 7/15/16 at 1:26 p.m., the treatment nurse (a licensed vocational nurse [LVN 1]) was asked for Resident 1's Braden Scale (an assessment tool for predicting pressure sore risk) from admission. LVN 1 and the facility's staff were unable to provide Resident 1's admission Braden Scale, but presented a Braden Scale, dated 3/2016. LVN 1 stated Resident 1 did not have any pressures sores upon admission to the facility.

On 7/15/16 at 2:40 p.m., during an interview, a certified nursing assistant (CNA 1) stated she took care of Resident 1 during the first week of admission and stated Resident 1 had no pressure sores, only redness under Resident 1's breast and stomach folds. CNA

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1 stated there was a pubic area mass. CNA 1 was asked how often she turned the residents in the subacute unit. CNA 1 stated the residents were supposed to be turned every two hours, but sometimes the residents were only turned once a shift when she was busy. CNA 1 stated, "I would like to turn the residents every two hours, but sometimes it's not possible, because it's only two CNAs in Sub Acute Unit (a higher level of care than a skilled nursing facility [SNF]). We have 10 residents each on an average shift and sometimes up to 12 residents on a shift, with most of the residents being bedbound (spends most of the time in bed) on ventilators. "

A review of Resident 1's skin assessment, dated 12/23/15, indicated Resident 1's right and left buttock and right groin area were excoriated (damage or remove part of the surface of (the skin) and the abdomen at the GT site was ulcerated.

A review of Resident 1's care plan, dated 12/25/15 (a month and half after admission), and titled, " High risk for skin breakdown, " related to abdominal surgical dehiscence (a surgical complication in which a wound ruptures along a surgical incision) abdominal wound, G-Tube ulceration (a sore on the skin or a mucous membrane), and excoriation of the left ischial (lower and back part of the hip bone), bilateral (both) buttocks, left abdominal fold, and the right groin, and diabetes, incontinence of bowel and bladder (B/B), fragile skin, limited mobility, and obesity. The staff's interventions included using pillows, pads, wedges to reduce pressure on heels and pressure points; and to turn and reposition Resident 1 every two hours and PRN (as needed).

A review of Resident 1's Braden Scale, initiated on 3/2/16, indicated the facility's staff scored Resident 1 with a score of 16 on 3/2/16 and 4/20/16; a score of 18 on 4/29/16; 17 on 5/9/16 and 5/11/16 and a score of 18 on 5/18/16. According to the Braden scale, a total score of 10-12 represented a high risk and 15-18 was a mild risk for developing pressure sores.

A review of Resident 1's laboratory results, dated 4/5/16, indicated a low albumin level at 2.8 g/dl (NRR 3.5-5.2) and a low pre-albumin level at 9.5 (NRR 18-33.8).

An article by NPUAP (National Pressure Ulcer Advisory Panel), dated 2009, indicated the nutrition was an important aspect of a comprehensive care plan for prevention and treatment of pressure ulcers and it was essential to address nutrition in every individual with pressure ulcers. Adequate calories, protein, fluids, vitamins and minerals are required by the body for maintaining tissue integrity and preventing tissue breakdown.

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On 7/15/16 at 3:02 p.m., during a concurrent interview and record review of Resident 1's Braden Scale, the director of nursing (DON) stated, after recalculating Resident 1's score, Resident 1 should have had a score of 12 (high risk) on all the assessments, as opposed to the score of 16-18 (a mild risk). The DON stated Resident 1's pressure sore risk was inaccurately assessed, which resulted in an inaccurate Braden Scale score. The DON stated an inaccurate assessment can result in an inaccurate plan of care for Resident 1. The DON stated the facility's Subacute Unit has 23 beds with only two CNAs to care for the high acuity (the level of severity of an illness) residents.

A review of the facility's policy, dated 1/1/12, and titled, "Pressure Ulcer Prevention," indicated the Licensed Nurse will develop a care plan that contains interventions for residents who have a Braden Scale score of 12 or less, and therefore considered to be a high risk for developing pressure ulcers. The policy stipulated the nursing staff will develop a care plan specific to the resident's risk factors and implement interventions identified in the care plan, which may include, but are not limited to pressure redistributing devices (per the attending physician's order), repositioning, heel and elbow protectors, use of pillows and linen rolls, moisturizers, and bowel and bladder training.

A review of a wound care assessment of pressure sores for Resident 1, dated 6/9/16, indicated the following:
* Pubic region necrotic wound measured 10 centimeter (cm) by 15 cm by UTD (unable to determine).
* 12. Right hip necrotic wound measured 8 cm by 4 cm by UTD.
* Left lower abdomen necrotic wound measured 11 cm by 7 cm by UTD.
* Left lateral thigh necrotic wound measured 1.5 cm by 2 cm by UTD.

On 7/18/16 at 9:12 a.m., during a telephone interview, Resident 1's family member (FM 1) stated he visited Resident 1 every day in the SNF and sometimes twice a day. FM 1 stated the facility did not provide good care in cleaning Resident 1 and he would have to ask them to turn her and or get her up out of the bed, as was ordered by the physician. FM 1 stated he was first informed in 5/2016 of Resident 1 having a blister (a small pocket of fluid within the upper layers of the skin) on the abdomen, but was told by a licensed nurse there was nothing to be concerned about. FM 1 stated it was not until 6/2016, when a certified nursing assistant (CNA 4) asked him if he had seen Resident 1's wounds. He stated he then spoke to the wound care physician and was told there were several wounds that were large and infected with a foul smell. FM 1 stated the

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	facility did not do any wound cultures of the Resident 1's wounds, although the wounds smelled and had drainage. FM 1 stated when he would ask the staff if they turned Resident 1, they would tell him Resident 1 refused, but Resident 1 would tell him they never asked. FM 1 stated on 6/29/16, at approximately 10 a.m., he called the facility and spoke to the registered nurse supervisor (RN 1) in the sub-acute unit. FM 1 stated RN 1, informed him Resident 1 was doing well without any problems. However, FM 1 stated he arrived at the facility about one hour later to find Resident 1 back on the ventilator with the oxygen saturation decreased to 92 to 93 percent (%), which was normally at 98 %, lying on her back, and unresponsive with eyes rolled back. FM 1 stated he was upset and had to insist that the facility called 911 due to Resident 1's change in mental status. FM 1 stated Resident 1's blood pressure was low upon his arrival at 60/30. FM 1 stated he was told by the GACH's physician Resident 1 was septic secondary to the many infected pressure sores. At 10:07 a.m., on 7/18/16, during a telephone interview, RN 1 (supervisor of the subacute unit) stated FM1 would visit Resident 1 and called all the time regarding her care and condition. RN 1 stated on the morning of 6/29/16, FM 1 had called and came to the facility. RN1 stated FM1 wanted Resident 1 transferred to the hospital, but he thought she was alright and did not need to go. RN 1 stated Resident 1 was lethargic and her heart rate was elevated, but her oxygen saturation was normal, but RN 1 stated they put Resident 1 back on the ventilator [sic]. RN 1 stated FM 1 was persistent in getting Resident 1 transferred to the hospital, so he called 911, because the basic ambulance would not have taken her with an elevated heart rate. A review of a the SNF's (skilled nursing facility) physician orders, dated 5/8/16, indicated Resident 1 can be up in chair from 8-10 a.m.,12-2 p.m. (on non-dialysis days), and 4-6 p.m. every day (7 days a week). A review of the Paramedic's Report, dated 6/29/16, and timed at 12:54 p.m., indicated Resident 1's GCS ([Glasgow Coma Scale] a scoring system for assessing the severity of brain impairment with sum of scores given for eye-opening, verbal, and motor responses [maximum of 15]). Resident 1's GCS score was 9 (GCS 9 -12 is Moderate impairment [3 for eye opening, 1 for verbal, and 5 for motor]) prior to being transported to the GACH. At 12:57 p.m., 6/29/16, Resident 1 had a low systolic blood pressure ([top number of blood pressure] amount of pressure that blood exerts on the vessels while the heart is beating) was under 78 (normal reference range [NRR]=120), the heart rate was 106 (NRR=60-100 BPM [beats per minute]), oxygen saturation was WNL (within normal limits) at 95 percent while Resident 1 receiving Bag-valve-mask (BVM) ventilation (an

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	essential emergency technique used for residents who are not breathing or not breathing adequately).Resident 1's respiratory rate was 16 and the blood sugar was elevated at 240 (NRR is 135 to 140 milligrams per deciliter [dl]). Resident 1's weight was 240 lbs. A review of Resident 1's GACH's emergency department [ED] record, dated 6/29/16, and timed at 1 p.m., indicated Resident 1's mental status was altered upon arrival to the GACH. Resident 1, who typically on a ventilator only at night, while at the SNF was placed on a ventilator continuously. A review of the GACH's history/physical for Resident 1 indicated Resident 1 was transferred from the SNF to the GACH due to an altered level of consciousness and shortness of breath. The ED's record indicated Resident 1 was lethargic (sluggish slow-moving or inactive) and unable to answer any questions. Resident 1's vital sign at 1:45 p.m. on 6/29/16 were as follows: Temp: 99.8 F (rectally [NRR= 99.6°F]), pulse at 100 BPM, Blood Pressure 111/33, respiratory rate at 16, and a pulse oximetry (saturation of oxygen in the blood) was 99 percent (%) on 100% Flo2 (fractional inspired oxygen). A review of Resident 1's GACH laboratory report, dated 6/29/16, indicated Resident 1 had a low albumin level (albumin is a serum protein produced in the liver that is essential for proper blood circulation, metabolism, and wound healing) of 2.4 grams per deciliter (g/dl), with a NRR listed as 3.2 - 4.8 g/dl, elevated white blood cell ([WBC] indicative of an infection) of 20.1 (NRR 4.3-10.0). The ED physician documented on the ED Encounter Form that Resident 1 was in moderate severe distress with a change in mental status that worsened due to underlying pneumonia versus sepsis with respiratory failure. The ED note indicated Resident 1 had multiple Stage IV decubitus ulcers with a foul odor. The ED physician documented Sepsis secondary to pneumonia and decubitus ulcers. The GACH's infectious disease (ID) consultation, dated 6/30/16, indicated Resident 1 was awake, but did not readily respond and had multiple decubitus ulcers. The ID physician (are trained in internal medicine and specialize in diagnosing, treating, and managing infectious diseases) documented Resident 1 had multiple Stage III-IV

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decubitus ulcers with some exposing bone and having necrotic tissue and having a foul smell. The ID physician indicated there was a large necrotic wound over Resident 1's inferior pannus (an abnormal layer of tissue) on the suprapubic (of the abdomen located below the umbilical [naval]) region.

A review of the pictures of Resident 1's various stages of Stage III-IV pressure sores from the GACH, dated 6/30/16 and 7/6/16, taken by a registered nurse treatment nurse indicated Resident 1 had foul smelling pressure sores on the following sites upon admission:

* Left upper posterior thigh
* Left lower abdomen
* Right hip with 50 % necrotic tissue; exposed bone measuring 10 cm by 4.5 cm by 2 cm in depth.
* Left thigh
* Right lower abdomen
* Lower abdomen (black in color unstageable; documented as larger wound with black eschar and foul smelling drainage)
* Coccyx (unable to determine stage by looking at the picture)

A review of Resident 1's GACH discharge summary, dated 7/19/16 indicated all of Resident 1's wounds had improved with less necrotic tissue with an improved clean base. The discharge summary indicated Resident 1's wounds no longer required a wound vacuum (a device which conducts negative pressure wound therapy (NPWT); device consists of a dressing which is fitted with a tube and attached to the wound). According to the discharge summary, Resident 1 was treated for drug resistant organism and placed in isolation receiving multiple IV antibiotics and antifungal medications. Resident 1 was weaned off ventilator support and was placed on 40% FIO2 trach collar (one-piece collar that secures tracheostomy tubes). Resident 1 transferred to another subacute facility on 7/19/16.

The facility failed to provide each resident with the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care, and to ensure that a resident who enters the facility without pressure sores does not develop pressure sores; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing, including but not limited to:

SECTION 1424 NOTICE

CITATION NUMBER: 94-1645-0012660-F

Date: 11/01/2016 Time: 9:22am

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	1. Failure to accurately assess Resident 1's risk for pressure ulcer development. 2. Failure to implement the facility's policy, dated 1/1/12, and titled, "Pressure Ulcer Prevention." 3. Failure to follow Resident 1's plan of care in pressure sore prevention in turning every two hours and keeping her clean and dry. 4. Failure to identify Resident 1's change in condition, which required an immediate attention, until Resident 1's family member insisted Resident 1 be transferred to the hospital. The above violations, jointly, separately, or in any combination presented an imminent danger that death or serious physical harm would result, or a substantial probability that death or serious physical harm would result.

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

POC accepted 11/1/16 JC

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
	055077	A. BUILDING _____ B. WING _____	09/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY VILLA BELMONT HEIGHTS HEALTHCARE CENTER	1730 Grand Ave, Long Beach, CA 90804-2011 LOS ANGELES 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 94-1645-0012660-F Complaint(s): CA00494101 Representing the Department of Public Health: Surveyor ID # 17013, SR HFEN The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. §483.25(c)(1-2) F 314 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. §483.25 F309 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive		***"Preparation, submission and/or execution of this 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 I. Corrective Action/s: Resident #1 a. Resident #1 was discharged to Long Beach Community Hospital on 06/29/16. b. LVN #3 is no longer employed at CV Belmont. c. DSD has given a 1:1 in-service with C.N.A. #1 regarding Turning and Repositioning Program on 09/22/16. Resident #4 a. Resident #4 was immediately cleaned and turned by the assigned C.N.A. and LVN. b. Resident #4 was placed on a scheduled Turning and Repositioning Program on 07/18/16 by DON. b. . LVN #3 is no longer employed at CV Belmont.	09/23/16

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

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s) 1 thru 16

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.

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	assessment and plan of care. The Department received a complaint on 7/1/16, alleging that a resident (Resident 1) arrived to the acute hospital, requiring a transfer to the intensive care unit (ICU) due to numerous Stage 3-4 pressure wounds on the hips, abdomen, and thigh area. Family expressed concerns regarding lack of care and treatment at the SNF. The facility failed to provide each resident with the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care, and to ensure that a resident who enters the facility without pressure sores does not develop pressure sores; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing, including but not limited to: 1. Failure to accurately assess Resident 1's risk for pressure ulcer development. 2. Failure to implement the facility's policy, dated 1/1/12, and titled, "Pressure Ulcer Prevention."		II. How to Identify Other Residents: A list of residents identified as high risk residents have been added in the Special Needs list by DON/Designee on 09/22/16 . 55 residents have been identified and their plan of care, as well as Braden Scale scores have been updated on 09/22/16 by DON and Treatment Nurses. III. Systemic Changes: a. DON/Designee in-serviced the Licensed Nurses on 09/22/16 regarding accuracy of completing Bradens Scale assessments, as well as timely completion of the assessments, including Pressure Prevention Policy & Infection Control. b. DSD/Designee in-serviced the CNAs and RNAs on the Turning & Repositioning Program and Skin Management and Pressure Ulcer Prevention on 09/21/6. c. Braden Scale assessments will be completed upon admissions x 4 weeks and PRN. d. New admission identified by Licensed Nurses as High Risk will be review by IDT during the Daily Stand Up Meeting for implementation of appropriate interventions and developments of Plan of Care. High Risk residents will be added to the Special Needs List. e. Quarterly and as needed, the Braden Scale assessments and Plan of Care will be completed & updated by MDS Nurse/Designee once identified as High Risk and added to the Special Needs list. f. Medical Records Designee will audit the Braden Scale x 4 weeks for completion from admission, as well as Plan of Care if identified as High Risk. Audits will be given to DON for follow through.	

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	3. Failure to follow Resident 1's plan of care in pressure sore prevention in turning every two hours and keeping her clean and dry. 4. Failure to identify Resident 1's change in condition, which required an immediate attention, until Resident 1's family member insisted Resident 1 be transferred to the hospital. These deficient practices resulted in Resident 1 not being identified as a high risk for pressure sores development; developing many Stage III and IV pressure sores; (Stage III =a deep wound, the loss of skin usually exposes some fat; Stage IV a pressure sore that is very deep, reaching into muscle and bone and causing extensive damage) that became infected; becoming unresponsive and requiring an emergency transfer (911) to a general acute care hospital (GACH) on 6/29/16. Resident 1 required an intensive care unit admission, fluid intravenously ([IV] into vein), multiple IV antibiotics and aggressive wound care twice a day, and pain medications. Resident 1 required a 21-day hospital stay for care and treatment of the many infected pressure sores that led to sepsis (a life-threatening condition in which the body is fighting a severe infection that has spread via the bloodstream) and was discharged on 7/19/16.		g. Skin Checks being completed by CNAs during Shower days and reports given to Licensed Nurses for follow through on any new treatment orders from MDs and Change of Conditions. h. Treatment Nurses Weekly Skin Schedules have been completed. New wounds identified will be referred to Wound MD on the next visit for further recommendations and monitoring. i. Any residents identified with wounds will be referred to the Wound Management Committtee for review and new recommendations for residents' Plan of Care. **IV. Monitoring:** DON/Designee will monitor and attend the Wound Management Committee to review findings and report findings during the Monthly QAA Meeting for trending and review for further recommendations.	

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	A review of Resident 1's Admission Face Sheet indicated Resident 1 was a 66 year-old female, who was initially admitted to the facility on 11/10/15, and most recently readmitted on 6/1/16. Resident 1's diagnoses included hypertension (high blood pressure), diabetes (high blood sugar) respiratory failure with a tracheostomy (an opening surgically created through the neck into the trachea (windpipe) to allow direct access to the breathing tube) requiring ventilator support (mechanical life support; breathing machine), dysphagia (difficulty swallowing) with a gastrostomy tube ([G-tube] feeding tube surgically placed through the skin and abdominal wall, for the introduction of food and fluids), end stage renal disease ([ESRD] last stage of chronic kidney disease [CKD] and dialysis or transplant is required to stay alive) requiring dialysis treatments (process of removing waste products and excess fluid from the body) three times a week (Monday, Wednesday, and Fridays [MWF]), morbid obesity (too much body fat for your height; is when the excess body fat becomes a danger to ones' overall health).. A review of Resident 1's skin assessment upon admission, dated 11/10/15, indicated Resident 1 had redness to the perineal area (between the vulva [external genital organs] and anus [rectum]) and surrounding the G-Tube area was a hard mass (a lump that can be within the skin, in the tissues, under the skin or attached to the skin and/or underlying tissues) to the		F309 I. **Corrective Action/s:** DON has given 1:1 in-service to licensed nurses involved with care of Resident #1 from 07/30/16- 07/31/16 regarding Q Shift Charting for Change of Condition on 09/23/16. II. **How to Identify Other Residents:** Other residents may potentially be affected from this deficiency. III. **Systemic Changes:** Licensed Nurses were given in-services on Change of Conditon Notification Policy and Q Shift Chartings by DON on 09/21/16. Any Change of Condition will be documented by Licensed Nurses in SBAR/Change of Condition Charting documentation and will be placed in 24 Hr. Report for follow through of Q Shift documnetations. Plan of Care will be updated by Licensed Nurses for any Change of Conditions identified by Licensed Nurses. Change of Condition will be discussed during the Daily Stand Up Meeting and any follow through documentations will be discussed to the IDT.	09/23/16

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	055077	A. BUILDING _____ B. WING _____	09/02/2016

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	lower abdominal fold area with no pain. A review of Resident 1's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 12/30/15, indicated Resident 1 was alert and oriented to person, place, and time as evidenced by the brief interview of mental status (BIMs) with a score of 15 (score of 8 to15=inter-viewable). The MDS, under Section G, Functional Status, indicated Resident 1 was totally dependent on staff requiring a two+ physical assist for turning in bed and of any slight position changes, movement on and off the unit, dressing, eating, toilet use, and personal hygiene, with the exception of eating, Resident 1 required a one-person physical assist. According to the MDS, Resident 1 was non-ambulatory and incontinent (unable to control) of bowel and bladder. On 7/15/16 at 1:26 p.m., the treatment nurse (a licensed vocational nurse [LVN 1]) was asked for Resident 1's Braden Scale (an assessment tool for predicting pressure sore risk) from admission. LVN 1 and the facility's staff were unable to provide Resident 1's admission Braden Scale, but presented a Braden Scale, dated 3/2016. LVN 1 stated Resident 1 did not have any pressures sores upon admission to the facility. On 7/15/16 at 2:40 p.m., during an interview, a certified nursing assistant (CNA 1) stated she took care of Resident 1 during the first week of		Medical Record Designee will do Change of Condition audits daily (M-F) for completion of Q Shift chartings. Findings will be given to DON/Designee for follow through. V. Monitoring: Medical Records Designee will report Change of Condition deficient findings during the Monthly CQI Steering Committee for review and further recommendations.	

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	admission and stated Resident 1 had no pressure sores, only redness under Resident 1's breast and stomach folds. CNA 1 stated there was a pubic area mass. CNA 1 was asked how often she turned the residents in the subacute unit. CNA 1 stated the residents were supposed to be turned every two hours, but sometimes the residents were only turned once a shift when she was busy. CNA 1 stated, "I would like to turn the residents every two hours, but sometimes it's not possible, because it's only two CNAs in Sub Acute Unit (a higher level of care than a skilled nursing facility [SNF]). We have 10 residents each on an average shift and sometimes up to 12 residents on a shift, with most of the residents being bedbound (spends most of the time in bed) on ventilators. " A review of Resident 1's skin assessment, dated 12/23/15, indicated Resident 1's right and left buttock and right groin area were excoriated (damage or remove part of the surface of (the skin) and the abdomen at the GT site was ulcerated. A review of Resident 1's care plan, dated 12/25/15 (a month and half after admission), and titled, " High risk for skin breakdown, " related to abdominal surgical dehiscence (a surgical complication in which a wound ruptures along a surgical incision) abdominal wound, G-Tube ulceration (a sore on the skin or a mucous membrane), and excoriation of the left ischial (lower and back part of the hip			

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	bone), bilateral (both) buttocks, left abdominal fold, and the right groin, and diabetes, incontinence of bowel and bladder (B/B), fragile skin, limited mobility, and obesity. The staff's interventions included using pillows, pads, wedges to reduce pressure on heels and pressure points; and to turn and reposition Resident 1 every two hours and PRN (as needed). A review of Resident 1's Braden Scale, initiated on 3/2/16, indicated the facility's staff scored Resident 1 with a score of 16 on 3/2/16 and 4/20/16; a score of 18 on 4/29/16; 17 on 5/9/16 and 5/11/16 and a score of 18 on 5/18/16. According to the Braden scale, a total score of 10-12 represented a high risk and 15-18 was a mild risk for developing pressure sores. A review of Resident 1's laboratory results, dated 4/5/16, indicated a low albumin level at 2.8 g/dl (NRR 3.5-5.2) and a low pre-albumin level at 9.5 (NRR 18-33.8). An article by NPUAP (National Pressure Ulcer Advisory Panel), dated 2009, indicated the nutrition was an important aspect of a comprehensive care plan for prevention and treatment of pressure ulcers and it was essential to address nutrition in every individual with pressure ulcers. Adequate calories, protein, fluids, vitamins and minerals are required by the body for maintaining tissue integrity and preventing tissue breakdown.			

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	On 7/15/16 at 3:02 p.m., during a concurrent interview and record review of Resident 1's Braden Scale, the director of nursing (DON) stated, after recalculating Resident 1's score, Resident 1 should have had a score of 12 (high risk) on all the assessments, as opposed to the score of 16-18 (a mild risk). The DON stated Resident 1's pressure sore risk was inaccurately assessed, which resulted in an inaccurate Braden Scale score. The DON stated an inaccurate assessment can result in an inaccurate plan of care for Resident 1. The DON stated the facility's Subacute Unit has 23 beds with only two CNAs to care for the high acuity (the level of severity of an illness) residents. A review of the facility's policy, dated 1/1/12, and titled, "Pressure Ulcer Prevention," indicated the Licensed Nurse will develop a care plan that contains interventions for residents who have a Braden Scale score of 12 or less, and therefore considered to be a high risk for developing pressure ulcers. The policy stipulated the nursing staff will develop a care plan specific to the resident's risk factors and implement interventions identified in the care plan, which may include, but are not limited to pressure redistributing devices (per the attending physician's order), repositioning, heel and elbow protectors, use of pillows and linen rolls, moisturizers, and bowel and bladder training.			

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	A review of a wound care assessment of pressure sores for Resident 1, dated 6/9/16, indicated the following: * Pubic region necrotic wound measured 10 centimeter (cm) by 15 cm by UTD (unable to determine). * 12. Right hip necrotic wound measured 8 cm by 4 cm by UTD. * Left lower abdomen necrotic wound measured 11 cm by 7 cm by UTD. * Left lateral thigh necrotic wound measured 1.5 cm by 2 cm by UTD. On 7/18/16 at 9:12 a.m., during a telephone interview, Resident 1's family member (FM 1) stated he visited Resident 1 every day in the SNF and sometimes twice a day. FM 1 stated the facility did not provide good care in cleaning Resident 1 and he would have to ask them to turn her and or get her up out of the bed, as was ordered by the physician. FM 1 stated he was first informed in 5/2016 of Resident 1 having a blister (a small pocket of fluid within the upper layers of the skin) on the abdomen, but was told by a licensed nurse there was nothing to be concerned about. FM 1 stated it was not until 6/2016, when a certified nursing assistant (CNA 4) asked him if he had seen Resident 1's wounds. He stated he then spoke to the wound care physician and was told there were several wounds that were large and infected with a foul smell. FM 1 stated the facility did not do any wound cultures of the Resident 1's wounds, although			

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	the wounds smelled and had drainage. FM 1 stated when he would ask the staff if they turned Resident 1, they would tell him Resident 1 refused, but Resident 1 would tell him they never asked. FM 1 stated on 6/29/16, at approximately 10 a.m., he called the facility and spoke to the registered nurse supervisor (RN 1) in the sub-acute unit. FM 1 stated RN 1, informed him Resident 1 was doing well without any problems. However, FM 1 stated he arrived at the facility about one hour later to find Resident 1 back on the ventilator with the oxygen saturation decreased to 92 to 93 percent (%), which was normally at 98 %, lying on her back, and unresponsive with eyes rolled back. FM 1 stated he was upset and had to insist that the facility called 911 due to Resident 1's change in mental status. FM 1 stated Resident 1's blood pressure was low upon his arrival at 60/30. FM 1 stated he was told by the GACH's physician Resident 1 was septic secondary to the many infected pressure sores. At 10:07 a.m., on 7/18/16, during a telephone interview, RN 1 (supervisor of the subacute unit) stated FM1 would visit Resident 1 and called all the time regarding her care and condition. RN 1 stated on the morning of 6/29/16, FM 1 had called and came to the facility. RN1 stated FM1 wanted Resident 1 transferred to the hospital, but he thought she was alright and did not need to go. RN 1 stated Resident 1 was lethargic and her heart rate was elevated, but her oxygen saturation was			

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	normal, but RN 1 stated they put Resident 1 back on the ventilator [sic]. RN 1 stated FM 1 was persistent in getting Resident 1 transferred to the hospital, so he called 911, because the basic ambulance would not have taken her with an elevated heart rate. A review of a the SNF's (skilled nursing facility) physician orders, dated 5/8/16, indicated Resident 1 can be up in chair from 8-10 a.m.,12-2 p.m. (on non-dialysis days), and 4-6 p.m. every day (7 days a week). A review of the Paramedic's Report, dated 6/29/16, and timed at 12:54 p.m., indicated Resident 1's GCS ([Glasgow Coma Scale] a scoring system for assessing the severity of brain impairment with sum of scores given for eye-opening, verbal, and motor responses [maximum of 15]). Resident 1's GCS score was 9 (GCS 9 -12 is Moderate impairment [3 for eye opening, 1 for verbal, and 5 for motor]) prior to being transported to the GACH. At 12:57 p.m., 6/29/16, Resident 1 had a low systolic blood pressure ([top number of blood pressure] amount of pressure that blood exerts on the vessels while the heart is beating) was under 78 (normal reference range [NRR]=120), the heart rate was 106 (NRR=60-100 BPM [beats per minute]), oxygen saturation was WNL (within normal limits) at 95 percent while Resident 1 receiving Bag-valve-mask (BVM) ventilation (an essential emergency technique used for residents who are not breathing or not breathing adequately).Resident 1's			

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	respiratory rate was 16 and the blood sugar was elevated at 240 (NRR is 135 to 140 milligrams per deciliter [dl]). Resident 1's weight was 240 lbs. A review of Resident 1's GACH's emergency department [ED] record, dated 6/29/16, and timed at 1 p.m., indicated Resident 1's mental status was altered upon arrival to the GACH. Resident 1, who typically on a ventilator only at night, while at the SNF was placed on a ventilator continuously. A review of the GACH's history/physical for Resident 1 indicated Resident 1 was transferred from the SNF to the GACH due to an altered level of consciousness and shortness of breath. The ED's record indicated Resident 1 was lethargic (sluggish slow-moving or inactive) and unable to answer any questions. Resident 1's vital sign at 1:45 p.m. on 6/29/16 were as follows: Temp: 99.8 F (rectally [NRR= 99.6°F]), pulse at 100 BPM, Blood Pressure 111/33, respiratory rate at 16, and a pulse oximetry (saturation of oxygen in the blood) was 99 percent (%) on 100% FIo2 (fractional inspired oxygen). A review of Resident 1's GACH laboratory report, dated 6/29/16, indicated Resident 1 had a low albumin level (albumin is a serum protein produced in the liver that is essential			

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	for proper blood circulation, metabolism, and wound healing) of 2.4 grams per deciliter (g/dl), with a NRR listed as 3.2 - 4.8 g/dl, elevated white blood cell ([WBC] indicative of an infection) of 20.1 (NRR 4.3-10.0). The ED physician documented on the ED Encounter Form that Resident 1 was in moderate severe distress with a change in mental status that worsened due to underlying pneumonia versus sepsis with respiratory failure. The ED note indicated Resident 1 had multiple Stage IV decubitus ulcers with a foul odor. The ED physician documented Sepsis secondary to pneumonia and decubitus ulcers. The GACH's infectious disease (ID) consultation, dated 6/30/16, indicated Resident 1 was awake, but did not readily respond and had multiple decubitus ulcers. The ID physician (are trained in internal medicine and specialize in diagnosing, treating, and managing infectious diseases) documented Resident 1 had multiple Stage III-IV decubitus ulcers with some exposing bone and having necrotic tissue and having a foul smell. The ID physician indicated there was a large necrotic wound over Resident 1's inferior pannus (an abnormal layer of tissue) on the suprapubic (of the abdomen located below the umbilical [naval]) region. A review of the pictures of Resident 1's various stages of Stage III-IV pressure sores from the			

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	GACH, dated 6/30/16 and 7/6/16, taken by a registered nurse treatment nurse indicated Resident 1 had foul smelling pressure sores on the following sites upon admission: * Left upper posterior thigh * Left lower abdomen * Right hip with 50 % necrotic tissue; exposed bone measuring 10 cm by 4.5 cm by 2 cm in depth. * Left thigh * Right lower abdomen * Lower abdomen (black in color unstageable; documented as larger wound with black eschar and foul smelling drainage) * Coccyx (unable to determine stage by looking at the picture) A review of Resident 1's GACH discharge summary, dated 7/19/16 indicated all of Resident 1's wounds had improved with less necrotic tissue with an improved clean base. The discharge summary indicated Resident 1's wounds no longer required a wound vacuum (a device which conducts negative pressure wound therapy (NPWT); device consists of a dressing which is fitted with a tube and attached to the wound). According to the discharge summary, Resident 1 was treated for drug resistant organism and placed in isolation receiving multiple IV antibiotics and antifungal medications. Resident 1 was weaned off ventilator support and was placed on 40% FIO2 trach collar (one-piece collar that secures tracheostomy tubes). Resident 1 transferred to			

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	another subacute facility on 7/19/16. The facility failed to provide each resident with the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care, and to ensure that a resident who enters the facility without pressure sores does not develop pressure sores; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing, including but not limited to: 1. Failure to accurately assess Resident 1's risk for pressure ulcer development. 2. Failure to implement the facility's policy, dated 1/1/12, and titled, "Pressure Ulcer Prevention." 3. Failure to follow Resident 1's plan of care in pressure sore prevention in turning every two hours and keeping her clean and dry. 4. Failure to identify Resident 1's change in condition, which required an immediate attention, until Resident 1's family member insisted Resident 1 be transferred to the hospital.			

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	The above violations, jointly, separately, or in any combination presented an imminent danger that death or serious physical harm would result, or a substantial probability that death or serious physical harm would result.		F-441 I. Corrective Action/s: One on one education was given to LVN#2 by DON/Designee on 09/23/16 regarding disposing of urinals/ covering labeling, and or cleaning them to ensure no cross contamination occurs . Urinals in rooms were removed by staff on 07/08/16 and replaced with new, labeled urinals. II. How to Identify Other Residents: Rounds were conducted by DSD and QA Nurse on 07/08/16 and no other residents were found to be affected by this practice. III. Systemic Changes: In service was conducted on 09/21/16 by DSD/Designee regarding Infection Control Policies: specifically labeling of disposable equipment and disinfecting equipment. DSD will continue to conduct observation rounds and see to it that infection control practices are being followed. Department Heads and Central Supply Supervisor will continue to perform ongoing rounds to validate urinals are labeled, empty, covered and/or disposed of. Findings will be reported to the Daily Stand Up Meeting for review and follow-up. IV. Monitoring: Any findings and trends will be reported to the Monthly CQI Steering Committee for review and recommendation by DSD.	09/23/16