ACCEPT 3/18/19 - CA

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

PRINTED: 03/04/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055845	A. BUILDING _____ B. WING _____	C 03/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEISURE GLEN POST ACUTE CARE CENTER	330 MISSION ROAD GLENDALE, CA 91205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of a complaint. Complaint number: CA00618528. Representing the Department: HFEN # 33670. Three deficiencies were issued for complaint number CA00618528.	F 000	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.	
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to accurately assess and provide the necessary care and services (wound treatments) by the physician, the physician designee (NP, Nurse Practitioner), the Director of Nursing (DON), the registered nurses, and the licensed vocational nurses (treatment nurses); after a resident sustained a deep skin tear on the right lateral (side) leg for one of three sampled residents (Resident 1). Cross Reference F 689.	F 684	**F684** **Quality of Care** **Corrective action for residents found to have been affected by this deficiency:** Resident 1's NP saw and examined right lower extremity wound on 1/2/19 with new orders given as followed: Triple antibiotic and hydrogel covered with dressing, Zinc and Vit C, Prostat TID and wound consultation. Resident 1's right lower leg wound resolved on 3/4/19. 100% epithelialized (completely resolved). No signs and symptoms of infections.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3/14/19

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 684	Continued From page 1 This deficient practice resulted to a wound infection of a MRSA (Methicillin Resistant Staphylococcus Aureus, an organism difficult to treat due to resistance to commonly used antibiotics) to resident's injury. Findings: A review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility, on 10/22/18, with diagnoses that included Parkinson's Disease (a progressive brain disorder that results in poor balance, trembling and stiffness of hands, arms, legs, jaw and face and slow movement), peripheral vascular disease (narrowing or blockage of blood vessels in the legs and arms that results in poor blood flow), and lymphedema (swelling of the arms or legs due to lymph fluid builds when the lymph system is damaged or blocked). A review of Resident 1's Minimum Data Set (MDS, a standardized resident assessment and care screening tool), dated 11/3/18, indicated resident was able to understand others and express her needs and wants, and required extensive assistance (resident involved in activity, staff provide weight bearing support) with two person physical assistance with bed mobility and transfers. A review of Resident 1's SBAR (Situational Background Assessment Report) Communication Forms, dated 12/13/18 timed at 10 a.m. by Licensed Vocational Nurse 3 (LVN 3), indicated, a Certified Nursing Assistant 1 (CNA 1) reported to the charge nurse that Resident 1 sustained right lower leg skin tear with skin flap and bleeding when the resident bumped leg on the footrest of	F 684	Maintenance supervisor changed the resident's wheelchair on 12/31/18. **Identification of residents with the potential to be affected by this deficiency:** DON and treatment nurses reviewed other residents with skin/wound concerns on 12/31/18. No other residents were affected by the deficient practice. Maintenance supervisor initiated safety checks of residents' wheelchairs on 01/02/19. No other residents were affected by the deficient practice. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not reoccur:** DON re-educate licensed nurses and IDT on 3/08/19 in regards to the following: • Skin/Wound management o Accurate assessments	

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F 684	Continued From page 2 Resident 1's wheelchair while transferring from the wheelchair to the bed and sustained a skin tear (a wound cause by shear, friction, and/or blunt force resulting in separation of skin layers) measuring 4.5 centimeter (cm) in length x (by) 1 cm. A review of Resident 1's Physician Order, dated 12/13/18, indicated to clean the right shin skin tear with Normal Saline (water with salt used to retard the growth of bacteria), pat dry, apply sterile strips (dressing strips that keep the tissues intact) and cover with dry dressing for 21 days then reevaluate. A review of Resident 1's Clinical Documentation-Skin Integrity Condition, dated 12/19/18 at 2:20 p.m. by LVN 2, indicated, Resident 1 wound size increased to length 3.8 cm x width 5.8 cm. x depth 0.3 cm. A review of Resident 1's Physician Order, on 12/19/18, indicated to clean the right shin skin tear with Normal Saline pat dry, apply triple antibiotic (medication used to treat infection) ointment and cover with dry dressing for 21 days then reevaluate. A review of Resident 1's medical records indicated no documented evidence that the NP assessed the wound prior to changing the wound treatment, dated 12/19/18, when the LVN 2 reported to the NP that the wound was not improving. A review of the Resident 1's Progress Notes, dated 12/19/18 timed at 12:33 p.m., LVN 2 documented received change in order. The note did not describe what order received, or why the	F 684	o Communicating with attending physician (accurate wound/skin conditions) and responsible party o Treatment protocols o Monitoring (documentations of progress or regressions) o Evaluation of interventions and updating attending physician o Wound consult if needed o IDT documentations and updating plan of care that involves physician's input DON and Treatment nurses received wound certification on 03/05/19. Administrator revisited and reviewed with the DON the job description for Director of Nursing on 03/07/19.	

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F 684	Continued From page 3 order was changed. On 12/31/18 at 10:15 a.m., during a wound treatment observation in Resident 1's room with LVN 1, Resident 1 was observed grimacing. The wound observed on the right leg had pink tissue with bright red blood oozing from an open deep wound. On 12/31/18 at 10:18 a.m., during an interview, LVN 1 explained, she initially assessed Resident 1's wound, as a "Skin tear," because the wound had a skin flap, however, the wound had increase in size and was now deeper. LVN 1 stated Resident 1 sustained the wound from a sharp edge metal on the side of resident's wheelchair during a transfer from a wheelchair to bed two weeks ago. On 12/31/18 at 11:19 a.m., during an observation in Resident 1's room and concurrent interview with the DON, the DON stated she had never seen or assessed the wound on 12/13/18. The DON stated the wound did not look like a skin tear. The DON stated the wound was a laceration (a cut or jagged wound). The DON stated a registered nurse and a physician should have assessed the wound to ensure accurate assessment for immediate interventions to prevent complication such as infection. On 12/31/18 at 11:47 a.m., during an interview, LVN 2 stated the wound treatment using the steri-strip was not working and the wound was not getting better. LVN 2 stated LVN 2 called the Nurse Practitioner (NP), on 12/ 19/18, for new treatment order. LVN 2 stated the NP changed the order to apply triple antibiotics to the wound. LVN 2 stated the NP did not physically assess	F 684	DON and/or RN supervisor will validate skin assessments by treatment nurses as it occurs for accuracy and give recommendations as needed. Then communicate assessments to the attending physician as needed. This will be an on-going process. DON will continue to conduct a weekly meeting with the treatment nurses in regards to skin/wound progress and status. The meeting will include accurate assessments, treatment protocols, attending physician notification of changes in wound status and treatments and evaluating and updating plan of care. **Measures that will be put into place to ensure that this deficiency does not reoccur:** The above POC will be reviewed in the QAPI committee for further review and recommendations monthly for 3 months and quarterly	

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F 684	Continued From page 4 Resident 1's wound on 12/19/18. On 12/31/18 at 1:10 p.m., during an interview, the NP stated she had not assessed Resident 1's skin tear on the right leg. The NP stated the staff reported Resident 1's skin tear was not improving, and the treatment was changed to triple antibiotic. The NP stated she did not order any laboratory test to check for infection of the wound or assessed the skin tear prior to changing the treatment. A review of Resident 1's Clinical Documentation-Skin Integrity Condition, dated 12/31/18 timed at 1:31 p.m. by LVN 2, indicated Resident 1 had a skin tear on the right anterior (front) lateral leg measuring 3 cm in length x 5.5 cm in width x 0.6 cm in depth. On 12/31/18 at 2:05 p.m., during an interview with the DON and concurrent review of Resident 1's medical records, there were no documented evidence that the Interdisciplinary Team (IDT, team of facility staff responsible to assess and plan the care of the residents) discussed with the responsible party and a care plan for resident's skin tear. The DON stated the IDT should have assessed the resident and developed a care plan. A review of the Physician's Progress Record, dated 1/2/19, indicated Resident 1 had painful right leg ulceration/laceration from a skin rupture (separate) with a wheelchair. The progress notes indicated the wound was infected and with erythema (redness), measured 2 cm x 3.5 x 1 cm that was cleaned with Dakins Solution (diluted bleach used as strong antiseptic that kills most forms of bacteria and viruses) and applied wet to dry dressing.	F 684	thereafter and as needed. DON will report trends.	3/15/19

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F 684	Continued From page 5 A review of Resident 1's Surgical Consult, dated 1/7/19, indicated a right anterior lower leg debridement (the removal of damaged tissue) performed by surgical excision due to 75 % wound slough (dead tissue, usually cream or yellow in color). The wound measured on length 3.0 cm x width 4.0 cm x depth described as unstageable tissue damage (UTD). A review of Resident 1's Laboratory Report, result date 1/8/19, indicated Resident 1's right leg skin tear was infected with MRSA. A review of Resident 1's Physician Order, dated 1/9/19 at 6:56 a.m., indicated to place Resident 1 on Contact Isolation for MRSA of the right lower leg wound, and to administer Vibramycin (medication used to treat infection) for ten days for the MRSA infection. A review of Resident 1's Laboratory Report, result date 1/15/19, indicated Resident 1's right leg skin tear continued to be infected with MRSA. A review of Resident 1's Surgical Consults, dated 1/21/19 and 2/11/19, indicated resident had repeat wound debridement. On 3/1/19 at 10:36 a.m., during a telephone interview, the facility's Medical Director (MD 1) stated for reported skin tear, he wound find out what happened, assess the wound, administer antibiotics, consult with the wound consult, and refer to the surgeon if needed. MD 1 stated MD 1 observed the treatment nurses (no specified date given), and stated, "The treatment nurses did not know what they were doing."	F 684		

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F 684	Continued From page 6 A review of the undated facility's job description, titled, "Treatment Nurse," indicated the primary job position of a treatment nurse was to provide primary skin care to residents under the medical direction and supervision of the DON, attending physician, and the Medical Director. A review of the undated facility's job description, titled, "Director of Nursing," indicated the DON will provided close supervision and direction to the nurses to continually improve the nursing care of the residents and will assume ultimate responsibility for coordinating plans for the total care of each residents, which comply with physician's order, government regulation and facility policies. A review of the facility's policy and procedure, dated 8/06, titled, "Physician's Services," indicated the resident's attending physician participated in resident assessment, care planning, monitoring changes, in resident's medical status, and providing consultation and treatment when called by the facility.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 689	**F689** **Free of Accident Hazards/Supervision/Devices** **Corrective action for residents found to have been affected by this deficiency:** Resident 1's wheelchair was replaced by the maintenance supervisor on 12/31/18.	

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F 689	Continued From page 7 review, the facility failed to prevent an accident and provide a safe, hazard free wheelchair when the wheelchair had a sharp edge, transfer by two-person assistance, and there was no investigation on the cause of the resident's injury from the wheelchair for one of three sampled residents (Resident 1). Resident 1 sustained a laceration (a deep cut or jagged wound) on the right lateral leg, on 12/13/18, from a sharp edge on the side of resident's wheelchair when a staff rushed to assist resident to avoid a fall. This deficient practice resulted to resident's wheelchair remained a hazard and the Director of Nursing (DON) did not assess Resident 1's injury sustained from the wheelchair until 12/31/18 (18 days after the injury). Findings: A review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility, on 10/22/18, with diagnoses that included Parkinson's Disease (a progressive brain disorder that results in poor balance, trembling and stiffness of hands, arms, legs, jaw and face and slow movement), peripheral vascular disease (narrowing or blockage of blood vessels in the legs and arms that results in poor blood flow), and lymphedema (swelling of the arms or legs due to lymph fluid builds when the lymph system is damaged or blocked). A review of Resident 1's Minimum Data Set (MDS, a standardized resident assessment and care screening tool), dated 11/3/18, indicated Resident 1 was able to understand others and express her needs and wants, and required extensive assistance (resident involved in activity,	F 689	There was an investigation conducted on 12/13/18 after the occurrence of the incident. DON provided a 1:1 counseling to the assigned CNA on 1/2/19 in regards to transferring resident from wheelchair to bed. **Corrective action for residents that may be affected by this deficiency:** Maintenance supervisor initiated safety checks of residents' wheelchairs on 01/02/19. No other residents were affected by the deficient practice. DON and/or DSD provided education to CNAs on 01/03/19 and 03/08/19 in regards to transferring of residents (wheelchair to bed/bed to wheelchair) which includes 1 or 2 person assistance. DSD started conducting random observation rounds in regards to transfer on 01/28/19, 01/29/19, 02/07/19, 02/09/19, 02/11/19 and	

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F 689	Continued From page 8 staff provide weight bearing support) with two person physical assistance with bed mobility and transfers. A review of Resident 1's SBAR (Situational Background Assessment Report) Communication Forms, dated 12/13/18 timed at 10 a.m. by Licensed Vocational Nurse 3 (LVN 3), indicated, a Certified Nursing Assistant (CNA 1) reported to the charge nurse that Resident 1 sustained right lower leg skin tear (a wound caused by shear, friction, and/or blunt force resulting in separation of skin layers) with skin flap and bleeding when the Resident 1 bumped leg on the footrest of while transferring from the wheelchair to the bed and sustained a skin tear measuring 4.5 centimeter (cm) in length x 1 cm. A review of Resident 1's Physician Order, dated 12/13/18, indicated to clean the right shin skin tear with Normal Saline (water with salt used to retard the growth of bacteria), pat dry, apply sterile strips (strips that keep the tissues intact) and cover with dry dressing for 21 days then reevaluate. A review of Resident 1's Clinical Documentation-Skin Integrity Condition, dated 12/19/18 at 2:20 p.m. by LVN 2, indicated, Resident 1 wound size increased to length 3.8 cm x width 5.8 cm. x depth 0.3 cm. A review of Resident 1's Physician Order, on 12/19/18, indicated to clean the right shin skin tear with Normal Saline pat dry, apply triple antibiotic (medication used to treat infection) ointment and cover with dry dressing for 21 days then reevaluate.	F 689	02/12/19 and no deficient practices were noted. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not reoccur:** DON will provide re-education training to licensed nurses and IDT by 03/0819 in regards to incident/accident management which includes investigation of the root cause, interventions, education to staff if needed and proper assessment and interventions, reporting and updating plan of care. Incident/accident will be reviewed by IDT daily during the stand up meeting. This will be an on-going process. Maintenance supervisor will conduct safety hazard rounds monthly on residents' wheelchairs.	

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F 689	Continued From page 9 On 12/31/18 at 10:15 a.m., during a wound treatment observation with LVN 1, Resident 1 observed grimacing when interviewed Resident 1 stated she had pain on the wound site but refused to take pain medication. The wound observed on the right leg had pink tissue with bright red blood oozing from an open deep wound. A review of Resident 1's Clinical Documentation-Skin Integrity Condition, dated 12/31/18 timed at 1:31 p.m. by LVN 2, indicated Resident 1 had a skin tear on the right anterior lateral leg measuring 3 cm in length x 5.5 cm in width x 0.6 cm in depth. On 12/31/18 at 2:00 p.m., during an interview and concurrent record review with the DON of Resident 1's medical records, the DON stated there was no documented evidence Resident 1 skin injury was investigated. The DON stated she should have investigated the incident of the exact cause of the skin injury such as checking the sharp edge on the wheelchair to determine the appropriate care. On 12/31/18 at 2:05 p.m., during an interview and concurrent record review with the DON of Resident 1's medical records, the DON stated resident's laceration was reported during the stand-up meeting that resident had a skin tear. The DON stated she did not observe or investigate the exact cause of the skin tear. The DON stated she was responsible to investigate any type of resident injury. On 12/31/18 at 2:22 p.m. during an observation and concurrent interview with LVN 3 and CNA 1, Resident 1 observed sitting on the wheelchair.	F 689	DON and/or DSD will provide education to CNAs by 03/08/19 in regards to the following: • Resident transfers (wheelchair to bed/bed to wheelchair) which includes 1 or 2 person assistance. • Reporting to maintenance and removing residents' equipment in the resident care area that could be a potential safety hazards. Department managers will monitor during daily rounds equipment that could be a potential safety hazards. Findings will be reported to administrator for follow-up. Administrator in-serviced rehab staff on 03/11/19 on monitoring wheelchairs for potential safety hazards. Findings will be reported to administrator for follow-up. **Measures that will be put into place to ensure that this deficiency does not reoccur:**	

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F 689	Continued From page 10 CNA 1 stated Resident 1 sustained a "Skin tear," and pointed at the side of resident's wheelchair that had a sharp edge without a rubber cap. CNA 1 stated the resident's wheelchair was the same wheelchair that caused the injury to resident's leg on 12/13/18. CNA 1 stated she transferred Resident 1 alone, and she should have had another staff to assist her. CNA 1 stated resident was heavy. CNA 1 stated the resident stood up, started losing balance, and had to move the resident into the bed right away to prevent the resident from falling. On 12/31/18 at 2:58 p.m. during an observation of Resident 1's wheelchair and interview, the DON stated the side of the wheelchair should have had a rubber cap to cover the sharp edge. The DON stated no one inspected the wheelchair after resident was injured to ensure the sharp edge was covered. A review of the facility's policy and procedure, dated 12/07, titled "Safety and Supervision of Residents," indicated the facility will provide safety and supervision to residents to prevent accidents. The policy and procedure indicated safety risk and environmental hazards were identified on an ongoing basis, and when an accident hazards were identified, and the Quality Assurance and Safety Committee (group of facility staff from different healthcare disciplines) shall evaluate and analyze the cause of the hazards and develop strategies to remove the hazards.	F 689	The above POC will be reviewed in the QAPI/QAA committee for 3 months and quarterly thereafter and as needed. Administrator and/or DON will report trends.	3/15/19
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services	F 710	**F710** **Resident's Care Supervised by a Physician**	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 710	Continued From page 11 A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the physician and the physician's designee (Nurse Practitioner) failed to assess and provide medical supervision for the care of an injury for one of three sampled residents (Resident 1). Resident 1 sustained a laceration (a deep cut or jagged wound) on the right lateral leg, on 12/13/18, from a sharp edge on the side of resident's wheelchair when a staff rushed to assist resident to avoid a fall. Cross Reference F 684 and F 689. The deficient practice resulted in delayed of necessary care and resident's wound injury became infected with a MRSA (Methicillin Resistant Staphylococcus Aureus, an organism difficult to treat due to resistance to commonly used antibiotics) on 1/8/19.	F 710	**Corrective action for residents found to have been affected by this deficiency:** Resident 1's NP seen and examined right lower extremity wound on 1/2/19 with new order given as follows: Triple antibiotic and hydrogel covered with dressing, Zinc and Vit C, Prostat TID and wound consultation. Resident 1's right lower leg wound resolved on 3/4/19. 100% epithelialized (completely resolved). No signs and symptoms of infections. **Corrective action for residents that may be affected by this deficiency:** DON and treatment nurses reviewed other residents with skin/wound concerns on 12/31/18. Residents' attending physician provided medical supervision and direction to the care to each resident. No other residents were affected by the deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055845	A. BUILDING _____ B. WING _____	C 03/04/2019

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F 710	Continued From page 12 Findings: A review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility, on 10/22/18, with diagnoses that included Parkinson's Disease (a progressive brain disorder that results in poor balance, trembling and stiffness of hands, arms, legs, jaw and face and slow movement), peripheral vascular disease (narrowing or blockage of blood vessels in the legs and arms that results in poor blood flow), and lymphedema (swelling of the arms or legs due to lymph fluid builds when the lymph system is damaged or blocked). A review of Resident 1's Minimum Data Set (MDS, a standardized resident assessment and care screening tool), dated 11/3/18, indicated resident was able to understand others and express her needs and wants, and required extensive assistance (resident involved in activity, staff provide weight bearing support) with two person physical assistance with bed mobility and transfers. A review of Resident 1's SBAR (Situational Background Assessment Report) Communication Forms, dated 12/13/18 timed at 10 a.m. by Licensed Vocational Nurse 3 (LVN 3), indicated, a Certified Nursing Assistant (CNA 1) reported to the charge nurse that Resident 1 sustained right lower leg skin tear (a wound caused by shear, friction, and/or blunt force resulting in separation of skin layes) with skin flap and bleeding when the resident bumped leg on the footrest of while transferring from the wheelchair to the bed and sustained a skin tear measuring 4.5 cm in length x 1 cm..	F 710	**Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not reoccur:** DON will revisit and re-educate licensed nurses on 03/08/19 on the following: • Skin/Wound management o Accurate assessments o Communicating with attending physician (accurate wound/skin conditions) and responsible party o Treatment protocols o Monitoring (documentations of progress or regressions) and communicate with the attending physician o Evaluation of interventions and updating attending physician o Wound consult if needed	

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F 710	Continued From page 13 A review of Resident 1's Physician Order, dated 12/13/18, indicated to clean the right shin skin tear with Normal Saline (water with salt used to retard the growth of bacteria), pat dry, apply sterile strips (strips that keep the tissues intact) and cover with dry dressing for 21 days then reevaluate. On 12/31/18 at 11:47 a.m., during an interview, LVN 2 stated the wound treatment using the steri-strip was not working and the wound was not getting better. LVN 2 stated LVN 2 called the Nurse Practitioner (NP), on 12/ 19/18, for new treatment order. LVN 2 stated the NP changed the order to apply triple antibiotics to the wound. LVN 2 stated the NP did not physically assess Resident 1. On 12/31/18 at 1:10 p.m., during an interview, the NP stated she had not assessed Resident 1's skin tear on the right leg. The NP stated the staff reported Resident 1's skin tear was not improving, and the treatment was changed to triple antibiotic. The NP stated she did not order any laboratory test to check for infection of the wound or assessed the skin tear prior to changing the treatment. On 12/31/18 at 2:05 p.m., during an interview and record review Resident 1's medical records, the Director of Nursing (DON) stated there was no documented evidence the physician or the NP physically assessed and evaluated if the treatment for Resident 1's laceration was appropriate. A review of the Physician's Progress Record, dated 1/2/19, indicated Resident 1 had painful right leg ulceration/laceration from a skin rupture	F 710	○ IDT documentations and updating plan of care that involves physician's input • Change in condition process ○ Accurate documentation of "Situations, Background, Assessments and Recommendations" (SBAR) to communicate to attending physicians ○ Through a detailed and thorough SBAR, the resident's physician will have a clear view and understanding of resident's full status or condition. This will prompt attending physician for an informed decision of resident's plan care and if treatment necessitates further consultations as needed • DON and IDT will review incident/accidents and COCs	

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F 710	Continued From page 14 with a wheelchair. The progress notes indicated the wound was infected and with erythema (redness), measured 2 cm x 3.5 x 1 cm.. A review of Resident 1's Laboratory Report, result date 1/8/19, indicated Resident 1's right leg skin tear was infected with MRSA. According to the facility's policy and procedure, titled "Physician's Services" the resident's attending physician participated in resident assessment, care planning, monitoring changes, in resident's medical status, and providing consultation and treatment when called by the facility.	F 710	daily to ensure that attending physician were notified timely of the current residents' condition. To ensure that plan of care were updated through the collaboration of IDT and attending physicians. This will be an on-going process **Measures that will be put into place to ensure that this deficiency does not reoccur:** The above POC will be reviewed in the QAPI/QAA committee for 3 months and quarterly thereafter and as needed. DON will report trends.	3/15/19