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

/2012
FORM APPROVED
MB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055318	A. BUILDING _____ B. WING _____	C 08/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLINE HEALTHCARE CENTER - SAN JOSE	2085 FOREST AVENUE SAN JOSE, CA 95128

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated survey regarding an entity reported incident, conducted on 7/25/12 through 8/16/12. For Entity Reported Incident CA00318769 regarding Accidents, Federal deficiencies were identified (see Federal tags 279, 281 and 514). Inspection was limited to the specific entity reported incident investigated and does not represent the findings of a full inspection of the facility. Representing the Department: 29766, Health Facilities Evaluator Nurse, and 26903, Health Facilities Evaluator Nurse.	F 000	**DISCLAIMER STATEMENT:** This Plan of Correction constitutes our written credible allegation of compliance. Preparation 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 the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. CALIFORNIA DEPARTMENT OF PUBLIC HEALTH AUG 31 2012 LICENSING AND CERTIFICATION SAN JOSE	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided	F 279	F-279 COMPREHENSIVE CARE PLANS Corrective action- Care plan for resident 1 with diagnosis of diabetic neuropathy and peripheral vascular disease was put in place on 8-15-12. Other residents-Medical records staff conducted an audit regarding care plan on 8-28-12. None of the other residents were affected by the same deficient practice. Newly admitted/re-admitted resident's charts will be reviewed during morning meeting to ensure that resident with diagnosis of Diabetic neuropathy and PVD, plan of care has been developed and put in place.	

LABORATORY DIR[redacted]

Any deficiency st[redacted] 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 279	Continued From page 1 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop a care plan for one of three sampled residents (1) for peripheral vascular disease (PVD, diseases of the blood vessels located outside the heart and brain) and neuropathy (abnormal condition of peripheral nerves). Findings: Resident 1's clinical record was reviewed on 8/16/12. Resident 1's 5/11/12 Minimum Data Set (an assessment tool) indicated he was cognitively intact and was self-responsible for his decisions. His admitting diagnosis included PVD. During an interview on 7/25/12 at 11:05 a.m., Resident 1 stated he sustained burns holding a cup of hot coffee with both of his hands while out on pass for a medical appointment. He stated he was unable to feel the burns because of his medical condition but did report the blisters to a staff member when he returned to the facility on the evening shift. During an interview on 7/25/12 at 8:15 a.m., the medical director (MD) stated during his weekly skin rounds with the infection control nurse on 7/19/12, Resident 1 complained of [illegible] blisters to both hands. The MD [illegible] areas with second degree burns (effects the outer and lower level of the skin with redness swelling and blistering) on both hands except for one part	F 279	Telephone orders will be reviewed during morning meeting to ensure that resident with any new diagnosis and skin condition has been care planned on timely manner. Resident with any new skin condition will be placed on 24 hrs report for 72 hrs monitoring as per protocol and plan of care will be develop accordingly. Resident comprehensive care plans will be reviewed during on admission, quarterly, annually and during care conferences by interdisciplinary team. Any changes with resident plan of care, MD and responsible party will be notified and plan of care will be updated accordingly. Systemic changes- license nurses were in service by Director of nursing on 8-15-12 regarding plan of care with resident whom has diagnosis of Diabetic neuropathy and peripheral vascular disease plan of care. Monitoring- Director of nursing/Designee will be responsible to monitor the process and any negative findings from audits will be brought to facility QA&A monthly meeting until compliance is sustained. Completion Date- 9-10-12	

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F 279	Continued From page 2 where there was third degree burn (effects layers of the skin and goes to a deeper level of tissue resulting in white or blackened skin) on the right hand. The MD recalled another incident when Resident 1 burned his hand while holding a cup of soup he heated in the microwave. The MD stated Resident 1 did not feel it because of his neuropathy. During an interview on 8/16/12 at 9:45 a.m., the unit manager verified no care plans addressing Resident 1's PVD or neuropathy problems were in place in the clinical record.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to have a policy in place related to how residents will be assessed when they leave or return to the facility on pass. Staff was inconsistent on the procedure to follow after residents returned from being out on pass. The staff failed to assess one of three samples residents (1) after he returned from pass. Resident 1 had burned his hands while out on pass and it was not discovered until the following day. The physician discovered he has second degree burns (affects the outer and lower layers of the skin with redness, swelling and blistering) on both hands except for one part where there was third degree burn (affects layers of the skin and goes to a deeper level of tissue resulting in white	F 281	Corrective action- Resident 1 skin assessment was done on 7-19-2012 by a license nurse and treatment order was done as per physician order. No other skin issues identified. Other residents- Medical record staff conduct an audit on resident whom recently went out on pass regarding skin assessment before leaving the facility and upon return, no other issues were identified. Resident with any new physician order for out on pass, chart will be brought to morning meeting to ensure that head to toe skin assessment was completed before resident left the facility and upon return. Any new skin condition identified during assessment will be reported to MD immediately and plan of care will be developed. Telephone	

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F 281	Continued From page 3 or blackened skin) on his right hand. The staff failed to follow the physician's order to change Resident 1's dressing twice a day. The care plans for Resident 1 indicated staff was to monitor for signs and symptoms of infection of skin tears in his hands. The staff did assessments during the dressing change but failed to do assessment when the order for dressing change was missed. Findings: Resident 1's clinical record was reviewed on 8/16/12. Resident 1's 5/11/12 Minimum Data Set (an assessment tool) indicated he was cognitively intact and was self-responsible for decisions. During an interview on 7/25/12 at 11:05 a.m., Resident 1 stated he sustained burns holding a cup of hot coffee with both of his hands while out on pass for a medical appointment. He also recalled having burned his hand previously about six to eight month ago by holding his hand over hot soup as he tried to maneuver his wheelchair. Resident 1 stated he told a staff member on evening shift but he could not remember who. During an interview on 8/16/12 at 7:05 a.m., certified nursing assistant A (CNA A) stated before sending the resident out on pass she gives an early breakfast, gives the resident their morning care, and checks vital signs and whatever the charge nurse instructs her to do. When they come back, she assists the resident to their room. If the resident returns around meal time, a meal tray is offered or snacks are offered. She does not normally check vital signs unless instructed by the charge nurse. During an interview on 8/16/12 at 7:10 a.m., CNA	F 281	orders will be brought to morning meeting with new physician order for out on pass to ensure the plan of care was reviewed during morning meeting and updated as needed. Systemic changes- License nurses were in-service by Director of nursing regarding resident with out on pass policy and procedure on 8/29/12 Monitoring- Director of nursing/Designee will be responsible to monitor the process and any new findings will be brought to the facility QA&A meeting monthly until compliance is sustained. Completion Date- 9-10-12	

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F 281	Continued From page 4 B stated when sending a resident out on pass, she makes sure the resident is stable. Transportation has been arranged, she will get the resident ready, giving the resident the morning care and seeing breakfast has been served. CNA B usually check vital signs, but this is not required. She also does skin assessment for bruises at times, but this is not required. During an interview on 8/16/12 at 7:30 a.m. with licensed nurse B (LN B), she stated residents usually go out on pass accompanied by a family member. She stated the charge nurse (CN) sends the resident to a medical appointment with copies of needed information for the doctor during the clinic visit. The CN also sends a blank doctor's order sheet and progress notes for instructions when they return to the facility. When they come back, they assess for any change in condition. During an interview on 8/16/12 at 8:45 a.m., LN C stated when a resident returns from pass, she stated they usually document the time. She stated the staff do things on a case by case basis and there is no specific standard of practice they follow. During record review on 8/16/12, a physician order dated 7/18/12 indicated to cleanse skin tears on nail beds from right ring finger, right middle finger and left ring finger with normal saline and apply triple antibiotic. Cover with dry dressing twice a day. During a review of Resident 1's clinical record on 8/16/12, a 7/18/12 skin tear care plan indicated to monitor skin tears for signs and symptoms of	F 281		

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F 281	Continued From page 5 infection on his fingers and hands. During an interview with the infection control nurse on 8/16/12 at 10:15 a.m., she stated the staff checks for signs and symptoms of infection during dressing changes and would document the assessments in the nurse's notes. During an interview on 8/16/12 at 4:05 p.m., LN A stated she did not do dressing change on Resident 1 on 7/18/12 evening shift as ordered. She also stated no assessment on Resident 1's fingers and hand were done when he returned from pass that night.	F 281		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to accurately record in a resident's clinical record when a dressing change was not done for one of three sampled residents (1). The dressing	F 514	Corrective action- 1:1 in-service was done on 8-29-12 by Director of Nursing regarding skin assessment, following physician orders, and treatment policy and procedure as well as documentation Other residents- Medical record conduct a random audit on resident with receiving skin treatments, no other issues to be identified. Resident with any new treatment orders, charts will be brought to morning meeting to ensure that physician orders are being carried out on timely manner and followed by a license nurse as per protocol Resident with refusal of treatment orders will be communicated to MD and RP. Any missed or resident with refusal of treatment order, License nurse will be	

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F 514	Continued From page 6 change was marked in the Treatment Administration Record (TAR) as being completed on the evening shift of 7/18/12. Resident 1's treatment administration record indicated a dressing change was done on 7/18/12 p.m. shift but a staff member stated she did not follow the physician's order and missed doing the dressing change. This failure led to burns on both hands not being discovered and assessed until the next day when the physician assessed Resident 1's hands. Findings: Resident 1's clinical record was reviewed on 8/16/12. Resident 1's Minimum Data Set (MDS, an assessment tool), indicated he was cognitively intact and self responsible for his decisions. During a record review on 7/25/12, the 7/18/12 physician's order indicated the skin tear on the right ring finger nail bed, right middle finger nail bed and left ring finger nail bed were cleansed with normal saline, triple antibiotic applied and covered with dry dressing twice a day. On 7/25/12 a review of the TAR indicated the dressing change was done on 7/18/12 evening shift and was signed by licensed nurse A (LN A). During a telephone interview on 8/3/12 at 2:40 p.m., LN A stated she was the charge nurse for the 3-11 shift on 7/18/12. She was unable to remember exact time Resident 1 returned from his medical appointment. LN A stated she returned to Resident 1's room after dinner to do the dressing change but Resident 1 was not in the room at that time. LN A stated she was not able to do the dressing change that shift as ordered.	F 514	responsible to circle the initial and document on back of the treatment record sheet with explanation of refusal of treatment and plan of care will be developed and reviewed as needed. Risk vs. benefits will be discussed by IDT and it will be documented in nurse's notes. Systemic changes- License nurses will be in-serviced by Director of nursing on 8-29-12 regarding following physician orders and treatment policy and procedure. Monitoring- Director of nursing/Designee will be responsible to monitor the process and any negative findings from audit will be brought to facility QA&A monthly meeting until compliance is sustained. Completion Date- 9-10-12. CALIFORNIA DEPARTMENT OF PUBLIC HEALTH AUG 31 2012 L & C DIVISION SAN JOSE	

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F 514	Continued From page 7 During an interview on 7/25/12 at 11:05 a.m., Resident 1 stated he sustained burns holding a cup of hot coffee with both of his hands while out on pass for a medical appointment. Resident 1 stated he told a staff member on the evening shift but he could not remember who. During an interview with the infection control nurse on 8/16/12 at 10:15 a.m., she stated the staff check for signs and symptoms of infection during dressing changes and would document the assessments in the nurse's notes During an interview on 8/16/12 at 4:05 p.m., LN A verified initials on TAR dated 7/18/12 were hers. She initialed the TAR prior to the dressing change. She meant to circle her initial indicating treatment was not done but never got back to the TAR. During an interview on 8/15/12 at 4:35 p.m., the assistant director of nurses (ADON) stated it is a standard of practice if a resident refuses medication or treatment, the licensed nurse initials and circles the space indicated for the medication or treatment. She stated they should also document the reason for it not being done at the back of the medication or treatment administration record. On 8/18/12 a review of the nurse's notes for the evening of 7/18/12 had no documentation of a failure to do the dressing change or the reason the change was not carried out.	F 514		