STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555053	A. BUILDING _____ B. WING _____	C 05/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELANO POSTACUTE CARE	729 BROWNING ROAD DELANO, CA 93215

(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 and abbreviated standard survey. Compliant Number: 581556 Representing the Department: 39763, HFEN 34510, HFEN The inspection was limited to the specific complaint investigation and does not represent the findings of a full inspection of the facility. One deficiency was issued for complaint number 581556.	F 000		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 686	Resident 2 was discharged from the	6/25/18

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

Electronically Signed | 06/27/2018

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F 686	Continued From page 1 review, the facility failed to: 1. Follow the facility's policy and procedure for Negative Pressure Wound Therapy and Hand Hygiene. 2. Ensure Licensed Nurses had the competencies to promote healing of a pressure ulcer (Damage to the skin or underlying structures from compression of tissue and inadequate perfusion.) for 1 of 3 sampled residents (Resident 2). These failures resulted in slow wound healing for Resident 2 and had the potential to spread infection to Resident 2's pressure ulcer and to other residents. Findings: During a review of the clinical record for Resident 2, the physician's order dated 3/8/18, indicated for the use of a wound vacuum (A specialized wound treatment system that utilizes negative pressure and a pump device to promote wound healing of severe wounds) and dressing changes every Monday, Wednesdays, and Friday for a pressure ulcer to Resident 2's left buttock. The Wound Clinic Notes for Resident 2 dated 3/21/18, indicated the pressure ulcer measured 3.5 centimeters (cm) in length, 5.3 cm in width and 3.7 cm in depth. The Wound Clinic Notes for Resident 2 written by the Wound Clinic Nurse WCN) dated 3/28/18, indicated "He (physician) was agitated at the wound vac (vacuum) placement by the SNF (Skilled Nursing Facility) and wants me (WCN) to assess what was wrong	F 686	facility on 4/9/18. All residents of the facility requiring wound care have the potential of being affected. In-service training for licensed staff was provided by the Interim Director of Nursing on 6/25/18 for "Negative Pressure Wound Vac Therapy" and "Hand Hygiene". Competency assessments were completed by the Interim Director of Nursing for all licensed nurses on wound care and hand hygiene 6/25/18. Competency assessments for wound care and hand hygiene will be completed by the Director of Nursing for all newly hired nurses during orientation and annually for all licensed nurses. The Director of Nursing will completed random weekly wound care observations of the LVNs to monitor for proper techniques, following policy and hand washing. The Director of Nursing will report the results of monitoring monthly to the Quality Assurance Performance Improvement (QAPI) Committee for review and recommendations.	

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F 686	Continued From page 2	F 686		

and why it wasn't working." The above Wound Clinic Notes indicated LVN 1 attended the 3/28/18 wound clinic appointment and was educated on the wound vacuum dressing change and placement. The Wound Care notes for Resident 2 dated 3/28/18, indicated the pressure ulcer measurements were unchanged from the previous appointment. The Wound Care notes for Resident 2 dated 4/3/18, indicated resident 2's pressure ulcer had improved after LVN 1 was educated on the use of the wound vacuum.

During an interview with Licensed Vocational Nurse 1 (LVN 1), on 4/12/18, at 9:16 AM, LVN 1 stated she was the SNF's treatment nurse. LVN 1 stated she received training on the use of the wound vacuum from LVN 3. LVN 1 stated she received a call from the physician and he tole LVN 1 the wound vacuum dressing change was not done correctly. LVN 1 stated she attended the scheduled wound clinic visit with Resident 2 on 3/28/18. LVN 1 stated the WCN had LVN 1 take her step by step through the procedure of changing the wound vacuum dressing. The WCN discovered that LVN 1 was missing a very important step. LVN 1 stated she was not cutting a hole into the clear dressing to allow for the suction of the wound vacuum to operate to maintain the negative pressure needed for wound healing.

During an observation of a dressing change for Resident 1 on 4/12/18, at 10:22 AM, it was observed that LVN 1 did not remove her gloves, wash her hands and then reapply new gloves after removing Resident 1's dirty dressing. LVN 1 remove scissors from her pocket and used them

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F 686	Continued From page 3 to cut the sponge that supported Resident 1's wound. Once the dressing change was complete, LVN 1 removed her gloves, washed her hands and then placed the scissors back into her pocket without cleaning them. During an interview with LVN 1, on 4/12/18, at 10:43 AM, LVN 1 stated she did not receive any formal wound management training. LVN 1 confirmed the above findings and agreed these actions could spread infection. During an interview with LVN 2, on 4/12/18, at 11:17 AM, LVN 2 stated she was trained by LVN 3 on the wound vacuum. LVN 2 stated, "We found out we were doing it wrong. We needed more training. We were not trained to cut a hole in the clear dressing to the sponge." During an interview with LVN 3, on 4/12/18 at 11:33 AM, LVN 3 stated, "I'm the one who missed the slit in it (Cut into clear dressing so the tube could suction and maintain negative pressure to promote healing)." LVN 3 stated she did not receive formal training on the wound vacuum and had not used one in 3 years. LVN 3 confirmed she trained LVN 1 and LVN 2 on the wound vacuum. During an interview with the Director of Nursing (DON), on 4/12/18, at 11:37 AM, the DON stated the facility does not have a system in place to monitor or evaluate Licensed Nurses' skills or competencies at this time.	F 686		

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F 686	Continued From page 4 The facility policy titled" Handwashing/Hand Hygiene" dated 8/15, indicated, "7. Use an alcohol-based hand rub ... g. After handling used dressings, contaminated equipment, etc.." "11. Wearing artificial fingernails is strongly discouraged among staff members with direct resident-care responsibilities, and is prohibited among those caring for severely ill or immunocompromised residents." The facility policy titled "Negative Pressure Wound Therapy " dated 2/14, indicated, "9. Apply adhesive pad with tubing to wound: a. Cut a hole in the barrier adhesive layer (Clear dressing) (...) so that the sponge/gauze is exposed."	F 686		