#55905 1/24/17

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

PRINTED: 12/29/2016
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
	056143	A. BUILDING _____ B. WING _____	C 12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OSAGE HEALTHCARE & WELLNESS CENTRE	1001 SOUTH OSAGE AVE INGLEWOOD, CA 90301

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F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during an investigation of a Complaint during an Abbreviated Survey Complaint Number: CA00512418 - Substantiated Representing the Department of Public Health: Surveyor ID: 34180, RN, HFEN Surveyor ID: 35385, RN, HFEN The inspection was limited to the specific Complaint and does not represent a full inspection of the facility Three deficiencies were written for Complaint Number: CA00512418	F 000	**Preparation, submission and/or execution of this Plan of Correction does not constitute admission or agreement by the CENTINELA SKILLED NURSING & WELLNESS CENTRE (OSAGE) 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 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that: - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents	F 323	**F 323** **CORRECTIVE ACTION(S):** **1.) Licensed nurse obtained an order Resident to go out-on-pass, as Resident is self-responsible, from attending physician on 12/5/16.** 12/5/16 **2.) Resident 7 initially had an order to go out-on-pass for therapeutic pass with a company or family dated 12/4/16 @ 8:45am. However, the out-on-pass order was clarified and changed to allowing Resident 7 to go out-on-pass as Resident deemed** 12/4/16	

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

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 323	Continued From page 1 (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure one of seven sampled residents (Resident 3) was not allowed to go out on pass unaccompanied without a physicians order for a period of 30 days, and the facility failed to ensure the licensed nurses (RN 1 and LVN 2) did not ask Resident 3 to allow Resident 7, (who had a physicians order to be out on pass with a companion or responsible party) to accompany Resident 3 out on pass. This resulted in Resident 3 leaving the facility and returning extremely intoxicated and resulted in Resident 7 leaving the facility without a responsible party or companion, which had the potential to result in Resident 7 not being able to recall the location of the facility and the potential to sustain an injury and having an accident. Findings: During an observation on 12/4/16, at 9:50 a.m.,	F 323	alert, oriented, capable and self-responsible, by his attending physician. 3.) 1:1 in-service training provided by Director of Nursing on 1/4/17 to LVN 2 regarding Out-on-Pass, in accordance to facility's policy, with emphasis on not allowing Resident to go out-on-pass with another Resident only, regardless of his physical condition and cognitive function, unless they are accompanied by their respective family member or responsible person that will both sign them out. 4.) 1:1 in-service training provided by Director of Nursing on 1/4/17 to RN 1 regarding Out-on-Pass, in accordance to facility's policy, with emphasis on not allowing Resident to go out-on-pass with another Resident only, regardless of his physical condition and cognitive function, unless they are accompanied by	1/4/2017 1/4/17

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F 323	Continued From page 2 Resident 7 was at the nurses' station and informed registered nurse 1 (RN 1) he wanted to leave the facility and go out on a pass (a process where residents are allowed to leave the facility for brief periods during the day) to attend an outside church service. RN 1 stated the resident is not allowed to leave the facility alone and required a chaperone (one delegated to ensure proper behavior) while out on pass. At the same time Licensed vocational nurse 1 (LVN 1) had also informed Resident 7 that his physician ordered a chaperone or family member to accompany the resident while out on pass. Resident 7 was observed pacing around the nursing station and continuously asking staff if he could leave the facility, when RN 1 and LVN 2 asked Resident 3 could Resident 7 accompany her for the day. Resident 3 stated that she was going to the store and when she returns Resident 7 could go with her. Resident 7 was observed at the nursing station and stated he was happy and thankful to the staff for allowing him to leave the facility. At 10:10 a.m., LVN 1 was asked about Resident 7's location in the facility. LVN 1 stated Resident 7 is currently in the dining room. A review of the "out on pass" book, indicated Resident 7 had signed himself out of the facility at 10:30 a.m. A review of the admission record indicated Resident 7 was originally admitted to the facility on 12/26/13 and re-admitted on 11/17/16 with diagnoses that included toxic encephalopathy (altered mental state caused by disease, damage or malfunction of the brain), muscle weakness, dementia (a condition characterized by a group of symptoms affecting intellectual and social abilities severely enough to interfere with daily functioning) without behavioral disturbances,	F 323	their respective family member or responsible person that will both sign them out. 5.) In-service provided by Director of Nursing on 1/4/17 to all staff in regards to Out-on-Pass vs Wandering and Elopement in accordance with facility's policy and procedure, with emphasis on making sure that Resident has an outstanding order for out-on-pass from their attending physician. 6.) Interdisciplinary team members (IDT) interviewed Resident 7 on 1/4/17 about his preferences / wishes for going out-on-pass and stated that Resident only wanted to go out-on-pass on the weekend to go to church and have lunch or dinner with a friend, which is his regular customary routine. Resident is self-responsible and no family involvement. Attending physician aware and agreed.	1/4/17 1/4/17

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F 323	Continued From page 3 abnormalities of the gait (manner of walking) and mobility, and diabetes (when the body fails to produce insulin and causes prolonged elevated blood sugar) A review of the elopement risk assessment dated 11/7/16 indicated that Resident 7 had a score of four which indicated the resident was not at risk for elopement. A review of Resident 7's plan of care titled " Altered thought process manifested by : Confusion,/Disorientation, Forgetfulness " dated on 11/17/16 indicated to provide verbal reminders which assist resident in orientation, explain all procedures and repeat instructions, and make simple instructions. A review of another plan of care titled "Psychosocial" dated 11/17/16 indicated Resident 7 had a problem with a change in health status, in the area of level of independence. The interventions included to orient resident to new environment, assess for negative emotions, anger, anxiety and depression. Redirect behavior provide education concerning residents' rights, provide to resident, responsible party, and staff regarding special care needs A review of the admission assessment dated 11/17/16 indicated Resident 7 required extensive assistance with bathing, dressing, hygiene, toileting, eating, transferring, ambulating and bed mobility. A review of the physician's orders dated 11/27/16, at 7:00 a.m., indicated Resident 7 may go out on a therapeutic (a cure or remedy) pass for four hours. Another physician's order dated 12/4/16 at 8:45 a.m., indicated Resident 7 may go	F 323	HOW TO IDENTIFY OTHER RESIDENTS: 1.) All Residents who goes out-on-pass based on Log where checked if outstanding order for out-on-pass are in place. No other Resident was affected. SYSTEMIC CHANGES: 1.) Social Service Designee will check facility Out-on-pass Log daily to ensure that Resident who signs out to go out-on-pass have an outstanding written order from their attending physician in their clinical record. 2.) Social Service Designee will check Out-on-pass log to ensure that it is completed, indicating the time out weekly, destination, name of person accompanying resident, and phone number to call in case of emergency and the time expected.. 3.) Director of Nursing will provide in-services to nursing staff regarding Out-on-Pass & wandering vs. elopement, in accordance to facility's policy, with emphasis on making	

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F 323	Continued From page 4 out on a therapeutic pass with a companion or a family member A review of the Minimum Data Set (MDS- a comprehensive assessment and care screening tool) dated 11/29/16 indicated Resident 7 was cognitively intact and required minimal assistance with one person assist for activities of daily living. A review of the physician's progress notes dated 12/2/16, indicated to continue with safety precautions for Resident 7 During an interview on 12/4/16 at 10:15 a.m., Resident 3 was asked if Resident 7 had accompanied her. Resident 3 stated "No", because she was taking Access (a public para-transit company for persons with disabilities) and did not inform the transportation company that she had an extra rider. During an interview on 12/4/16 at 10:20 a.m., RN 1 stated that she searched the entire facility including the facility's parking lot and the retirement area of the facility located between the East and West buildings. However, RN 1 was not able to locate Resident 7. RN 1 stated she notified the Administrator, the Director of Nursing (DON), staff in activities and had stopped searching for the resident. During an interview on 12/4/16 at 10:50 a.m., LVN 2 was asked if it is the facility's standard practice to allow residents to act as a companion or chaperone for another resident while out of the facility/out on pass, LVN 2 stated "No." During an interview on 12/4/16 at 11:00 a.m., RN 1 was asked if the facility's policy indicated that a resident in the facility may act as a chaperone or a companion for another resident while out on pass/out of the facility, RN 1 stated "No." During an interview on 12/4/16 at 12:45 p.m. the	F 323	sure that attending physician to include whether the Resident should be accompanied by a responsible person while out on pass or may leave the facility unaccompanied. In the absence of a specific order that indicates the Resident may go out on pass unaccompanied, the Resident may be accompanied by a responsible person. MONITORING PROCESS: Findings will be presented and discussed with QA Committee monthly x 6 months for further resolution and recommendations	

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Administrator stated Resident 7 did not elope from the facility because he signed himself out of the facility. The Administrator further stated that Resident 7 was at church and was not missing.
During an interview on 12/4/16 at 1:35 p.m., RN 1 stated Resident 7 was alert and oriented to name, place and time with periods of forgetfulness.
At 3:40 p.m., the DON stated Resident 7 had not returned to the facility and the local police was called.
At 5:00 p.m., Resident 7 had not returned to the facility.
During an interview at 6:25 p.m. LVN 5 stated Resident 7 had just returned to the facility.
During an interview on 12/4/16 at 6:40 p.m., Resident 7 stated that he did not attend church today, he went to lunch, but could not remember the name of the restaurant.

During an interview on 12/4/16 at 7:00 p.m., Resident 3 was observed to be intoxicated. At the same time LVN 5 stated Resident 3 was intoxicated with alcohol, which was not her normal behavior and she did not have an order to leave the facility out on pass.
At 8:05 p.m., Resident 3 becoming increasingly upset due to a scheduled deep cleaning in her room. Resident 3 began swearing and stated "Yeah, I have been drinking, is there a law against drinking."
A review of the admission record indicated Resident 3 was admitted to the facility on 8/30/16, with diagnosis that included chronic obstructive pulmonary disease (COPD - a lung disease causing a cough and shortness and breath) and pneumonia (infection of the lungs).

A review of the MDS dated 11/1/16 indicated the resident had no cognitive impairment and

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F 323	Continued From page 6	F 323		

required extensive assistance from facility staff in dressing, toileting, and personal hygiene.
A review of the recapitulated physician's orders for 8/2016, 9/2016, 10/2016, 11/2016 and 12/2016 did not indicate an out on pass order for Resident 3.
A review of the nurses notes dated 11/24/16 timed at 8:45 a.m. indicated Resident 3 left the facility without an out on pass order. The resident was administered Norco (a controlled medication used to relieve pain) and Benadryl (a medication used for allergies and causes drowsiness) at 8:30 a.m. prior to leaving the facility.
A review of the change of condition nurses notes dated 12/4/16 and timed between 3 p.m.-11 p.m., indicated Resident 3 had an episode of alcoholic intoxication and stated "I drink every single day."
A review of the facility's out on pass sheet including the date and time in and out of the facility and the destination indicated Resident 3 had been leaving the facility from 9/4/16 to 12/4/16 at various times of the day.

Date	Time Out	In	Destination
9/4/16	11:00am	5:50pm	unknown
9/5/16	10:30am	5:30 pm	doctors appt. & pharmacy
9/8/16	1:30 pm	blank	blank
9/10/16	2:35 pm	7:00 pm	blank
9/14/16	11:10 am	blank	blank
9/16/16	4:30 pm	8:15 pm	blank
9/18/16	11:30 am	blank	blank
9/22/16	11:45 am	1:50 pm	blank
9/23/16	11:15 am	8:25 pm	blank
9/24/16	10:00 am	blank	blank
10/7/16	3:30 pm	3:50 pm	got cigs
10/8/16	7:30 pm	7:55 pm	blank
10/10/16	9:20 am	9:40 am, 1:35 pm	

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blank

10/10/16	5:45 pm	6:00 pm	blank
10/11/16	10:45 am	blank	store
10/12/16	9:20 am	blank	blank
10/21/16	1:00 pm	1:40 pm	blank
10/23/16	12:45 pm	5:20 pm	blank
10/30/16	9:20 am	9:30 am	store
10/30/16	9:25 am	11:15 am	church
10/31/16	10:10 am	10:30 am	store
10/31/16	4:15 am	5:00 pm	hospital visit
11/17/16	11:15 am	12:50 pm	Wing Stop restaurant
11/17/16	3:30 pm	3:50 pm	store
11/18/16	11:30 am	1:10 pm	store
11/18/16	3:30 pm	5:10 pm	blank
11/19/16	8:10 am	5:45 pm	blank
11/21/16	2:30 pm	blank	blank
11/22/16	8:30 am	12:35 pm	blank
11/22/16	4:10 pm	5:10 pm	store
11/23/16	9:15 am	2:20 pm	blank
11/23/16	4:50 pm	blank	store
11/24/16	9:00 am	blank	blank
11/27/16	10:30 am	blank	church
11/29/16	3:50 pm	4:10 pm	store
11/30/16	9:00 am	3:20 pm	blank
11/30/16	5:20 pm	blank	blank
12/2/16	2:40 pm	blank	blank
12/3/16	12:40 pm	1:20 pm	store
12/3/16	4:20 pm	4:45 pm	store
12/3/16	7:25 pm	7:45 pm	store
12/4/16	9:45 am	10:00 am	store
12/4/16	10:30 am	blank	blank
12/4/16	12:00 pm	6:50 pm	church

A review of the facility's revised policy dated 1/11/16 and titled "Out On Pass" indicated the Attending Physician's order should include whether the resident should be accompanied by a

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F 323	Continued From page 8 responsible person while out on pass or may leave the facility unaccompanied. In the absence of a specific order that indicates the resident may go out on pass unaccompanied, the resident must be accompanied by a responsible person.	F 323	F 441 CORRECTIVE ACTION(S): 1.) All 6 Residents identified with rashes on body were immediately placed on presumptive contact isolation precaution 12/2/16, and will remain on contact isolation precaution until cleared by Dermatologist. 12/2/16 2.) In-services was immediately provided and initiated on 12/2/16 by Director of Nursing to direct patient-care staff on 3-11 shift and will continue to provide series of in-services with regards to infection control management, placing emphasis on care & management of skin rashes with unknown etiology. In service will continue until all staff are captured and completed. No direct-care staff will provide Resident's care until they have been provided in-service. 12/2/16	
F 441 SS=J	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 441		

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to be followed to prevent spread of infections.

(iv) When and how isolation should be used for a resident, including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to identify the cause of skin rashes for four of 50 sampled residents (Residents 1, 2, 3, 4), who developed skin rashes while residing in the facility from September 2016 to December 2016.

3.) 1:1 in-service/training was provided to treatment nurse (LVN) involved on 12/2/16 by the Director of Nursing Designee in regards to Skin care & management, with emphasis on notifying the physician & Director of Nursing regarding skin rashes not responding to current treatment order. 12/2/16

4.) Dermatologist was called on 12/2/16 to evaluate all 6 Residents identified with rashes on body, and Dermatologist arrived at the facility on 12/2/16. 12/2/16

5.) Dermatologist identified 4 Residents with undiagnosed rashes on body & suspected scabies. Skin scraping ordered immediately on 12/2/16. 12/2/16

6.) Skin Mapping and surveillance initiated and completed to all 6 Residents identified with skin rashes on 12/2/16. 12/2/16

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F 441	Continued From page 10 As a result, Resident 1's family member contracted scabies and was diagnosed by her physician to have scabies. Also, Resident 1, 2, 3 and 4 had not received appropriate treatment for their skin rashes which resembled signs and symptoms of scabies. Additionally, the facility failed to ensure and maintain accurate infection control practices and surveillance for Resident 1, 2 , 3, and 4, who had a rash for more than 90 days, which was not responding to treatment and had not been seen by a Dermatologist and was not tested for scabies. Additionally, the facility's DSD, licensed nurses LVN 3, LVN 4 and LVN 5, who were aware of the skin conditions of the residents failed to follow-up with the Dermatologist, as indicated in the facility's policy. Additionally, the MD 1 failed to wash his hands before and after direct contact with Resident 1, 2 3 and 4. Also, the facility failed to follow its policy for "Prevention and Control of Scabies in California in Longterm Facilities" by failing to report an outbreak (Two or more confirmed cases or one confirmed case and at least two suspected case) of suspected cases to the Department. These deficient practices had the potential to result in ineffective control of the transmission of scabies and a lack of immediate action and placed all residents, staff, and visitors at risk of exposure to scabies. Findings: On 12/1/16, an unannounced visit was made to the facility to investigate allegations the facility is not addressing or correcting the problem of scabies. The allegations indicate steff, visitors and residents have contracted scabies.	F 441	7.) Skin scraping order done by Director of Nursing to all 4 Residents on 12/3/15. Result of skin scrapping of 4 Resident with suspected scabies done received on 12/3/16, and all were found negative. 12/3/16 8.) California Department of Public Health was called on 12/3/16 @ 11:15am and 11:20am. 4 Residents with suspected scabies were reported to CDPH Communicable disease physician Dr. Bam Schwartz on 12/3/16 at 2:30pm. In addition, a letter was faxed to California Department of Public Health at (888)397-3778. 12/3/16 9.) Another skin scraping procedure done by Dermatologist to all 4 Residents with suspected scabies on 12/3/16, results were received on 12/4/16. All 4 Residents were found negative. 12/3/16 – 12/4/16	

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F 441	Continued From page 11 A review of the admission record indicated Resident 1 was originally admitted to the facility on 9/01/16, and re-admitted on 9/13/16, with diagnoses that included sepsis (an infection in the blood), encephalopathy (altered mental state caused by disease, damage or malfunction of the brain) and dementia (a condition characterized by a group of symptoms affecting intellectual and social abilities severely enough to interfere with daily functioning) A review of the Minimum Data Set- (MDS - a comprehensive assessment and care screening tool) dated 11/16/16, assessed Resident 1 as having intact cognitive patterns were required extensive to total dependence with one to two person physical assistance with transfers, dressing, toilet use and personal hygiene A review of the admission skin assessment dated 9/2/16, indicated Resident 1 had an upper back rash. A review of a plan of care for Resident 1 titled "Skin Rash" dated 9/2/16, included to administer treatment as ordered, monitor rash and advise the physician of progress and/or complications, and obtain a dermatologist consultation and follow-up as needed. A review of the physician's orders dated 9/2/16, at 7 a.m., indicated to apply Triamcinolone (a medication used for reducing itching, redness, and swelling associated with many skin conditions) cream daily for 30 days. A review of the physician's progress notes dated 9/7/16 indicated Resident 1 had a rash with	F 441	10.) A series of in-services provided by the Director of Nursing Designee to all staff initiated on 12/2/16, in regards to Skin care & management, with emphasis on notifying the charge nurse of any Resident with a skin rash. 11.) All 4 Residents found with rashes and found negative with scabies, per skin scraping results declared clear by their respective attending physician on 12/4/16. Isolation precaution orders were discontinued on 12/4/16, as per attending physician's ordered. 12.) ADDENDUM: The Public Health Nurse and the Public Health Nurse Supervisor visited the facility on 12/8/16 and provided the following recommendations that were immediately implemented by the facility staff on 12/8/16. The recommendations are as follows: • The facility identified the index case	12/2/16 12/4/16 12/8/16

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raised erythematous papules (patches of redness) to the entire trunk (upper body), upper extremities (arms and legs) and was pruritic (itching). The physician's documented plan indicated Resident 1's body rash was suspected (suspicious) of scabies, and to treat the resident with Elimite (an anti-parasitic medication that paralyze and kill mites and their eggs) cream including an additional treatment and the plan suggested to treat the roommates (Resident 2 and Resident 3) as well.

A review of the physician's orders dated 9/7/16, at 2:30 p.m., indicated to apply Elimite Cream 5 % to Resident 1's entire body one time and repeat the treatment once in 14 days of itching.
A review of the nurses' notes dated from 9/2/16 to 9/7/16 indicated Resident 1's skin was warm and dry to touch. On 9/8/16, between 3 p.m. to 11 p.m., Resident 1 received Elimite treatment.
A review of Resident 1's treatment records indicated the resident was treated for an upper back rash with Triamcinolone cream 0.1 % from 9/2/16 to 9/4/16, 9/6/16 to 9/20/16, 9/22/16 to 9/24/16 and 9/26 to 9/30/16. Additionally, the treatment record indicated Resident 1 was treated with Elimite on 9/8/16 and again on 9/22/16.

A review of the physician's orders dated 10/3/16 at 9 a.m., indicated to treat Resident 1's upper back rash with Triamcinolone ointment 0.1 % daily for 30 days.
A review of the nurses' notes dated 10/3/16 at 9 a.m. indicated Resident 1's back rashes were improving but had not resolved.
A review of the physician's orders dated 10/14/16, at 9 a.m., indicated to discontinue the Triamcinolone treatment, Resident 1's upper back

- Scabies outbreak Line Listing for Employees
- Scabies outbreak line listings for Residents affected
- Re-isolate the 4 Residents identified for suspected scabies.
- Notice posted directing staff & visitors entering the facility to report to licensed nurse(s). The facility made the effort to contact visitors & family members of the 4 suspected affected Residents of signs & symptoms of skin rashes and/ or scabies.

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F 441	Continued From page 13 rash was resolved. Further review of Resident 1's treatment records indicated the resident was treated for an upper back rash with Triamcinolone ointment 0.1 % from 10/3/16 to 10/14/16. The treatment record indicated the treatment was resolved on 10/14/16. A review of the nurses' notes on the following dates: 10/6/16, 10/12/16, 10/13/16, 10/17/16 10/18/16, 10/19/16 and 10/20/16 indicated that Resident 1 had a general body rash. After further review there was no treatment record for November 2016 for Resident 1. A review of the nurses notes titled change of condition dated 11/12/16 for the 3 p.m. to 11 p.m shift indicated Resident 1 had red bumps to the left hand and bilateral (both sides) underarms. A review of the nurses' notes dated 11/16/16 for the 11 p.m. to 7 a.m. shift, indicated Resident 1's red bumps to the left hand and both underarms were in the healing process A review of the physician's orders dated 11/22/16, at 5:30 p.m. indicated to obtain a Dermatologist (a medical doctor that treats disease and conditions of the skin) consult for Resident 1 However, there was no documented evidence the Dermatologist consult was ever done. A review of the nurses' weekly summary for Resident 1 for the following dates: 8/31/16 thru 9/7/16, 9/7/16 thru 9/14/16, 9/14/16 thru 9/21/16, 9/28/16 thru 10/5/16 and 11/16/16 thru 11/23/16 indicated there was no documented skin assessment, but there was a notation to refer to the treatment book. A review of Resident 1's Surveillance Data	F 441	• Treatment offered & provided to employee(s) • Treatment provided to affect Residents. • All affected Residents & employees were simultaneously being treated. • Moving forward, the facility will notify the local health officer of any and all of outbreaks. 13.) 1:1 in-service provided to Dermatologist by Director of Nursing Designee on 1/3/17 in regards to hand hygiene, with emphasis on proper handwashing in between procedure. HOW TO IDENTIFY OTHER RESIDENTS: 1.) Resident's skin check/ sweep initiated and completed on 12/2/16. No other Residents affected.	1/3/17 12/2/16

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F 441	Continued From page 14 Collection Form, completed by the DSD dated on 12/2/16, indicated the resident had no current maculopapular (red, flat area of the skin covered with bumps) and/or itching rash. During an interview on 12/1/16, at 8:30 a.m., the Director of Staff Development (DSD) stated there is no documentation in the facility's surveillance infection log indicating Resident 1 had a rash or suspected scabies and stated Resident 1 should have been added to the surveillance log. The DSD stated that she was informed by Resident 1's family member (FM 1) two to three weeks prior that the resident had a history of scabies. The DSD further stated that she had performed a visual inspection of Resident 1's skin and the resident was treated prophylactically with Elimite cream. During an interview on 12/1/16 at 1:55 p.m., Licensed Vocational Nurse (LVN 4) stated Resident 1 had a red spotty rash on both arms two weeks ago and was treated. However no labs were performed to confirm scabies and she did not initially check the resident's skin. LVN 4 stated Resident 1's FM 1 took the resident to her private dermatologist. She further stated she did not follow-up on the facility's dermatology consult order dated 11/22/16. LVN 4 further stated that Resident 1 was not placed on contact isolation during that time. During an interview on 12/1/16, at 3:00 p.m., LVN 3 (treatment nurse) stated that she would notify the physician about any resident with a rash or suspected scabies. She further stated if the rash was not improving she would suggest a dermatology consult for further skin evaluation. LVN 3 further stated that Resident 1's family member had taken the resident to an outside	F 441	2.) All direct patient-care employees scheduled on 12/2/16 on 3-11 shift were interviewed and assessed for signs/ symotoms of rashes. No affected employees reported on 3-11 shift. 3.) Completion of interviews and assessment of all direct patient-care employees completed on 12/5/16. No affected employees reported. With symptoms of scabies. SYSTEMIC CHANGES: 1.) Director of Nursing will make rounds weekly with the Treatment nurse to review all wounds and skin abnormalities. 2.) Treatment nurse will do skin sweep weekly and any findings of rashes noted on Resident's body will be reported to Infection Control Preventionist for proper identification and management within 24 hours upon identification.	12/2/16 12/5/16

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F 441	Continued From page 15 dermatologist and had no knowledge of the outside dermatologist results and was not sure if a skin scrapping were performed. LVN 3 was asked if Resident 1 currently had a rash and was seen by a dermatologist, LVN 3 stated "No" and stated Resident 1 was not receiving skin treatment for the month of November 2016. When asked if any employees involved with the resident's care were treated prophylactically, LVN 3 stated all employees were offered prophylactic treatment, but had never received the treatment. During an interview on 12/2/16 at 7:40 a.m., LVN 5 stated that Resident 1 had a red itchy rash on her stomach and left arm last month (November) and was treated with a cream that is placed on the entire body at night then showered off in the morning. LVN 5 stated that she was not aware of any other residents with skin rashes. LVN 5 further stated that she personally had developed a small red rash on her left wrist area but believed that it was from laundry detergent. LVN 5 stated she was never offered prophylactic treatment and asked LVN 3 before leaving work on 12/1/16 about the bump on her left wrist. LVN 3 stated the bump on LVN 5's left wrist was similar to the rash on Resident 3. During a shower observation on 12/2/16 at 9 a.m., Resident 1 had no rash. During an interview on 12/2/16, at 2:16 p.m., LVN 3 stated that she should have followed-up on the findings, but did not. LVN 3 further stated she was responsible for performing weekly skin checks/sweeps on all residents and had stopped after the prior DON left the facility in July 2016. LVN 3 stated she was offered prophylactic treatment from the prior DON but never used it.	F 441	3.) Infection Control Preventionist will conduct Surveillance Data Collection for proper identification, interventions and reporting. 4.) Any newly admitted Resident with an undiagnosed rash will be placed on contact isolation until a diagnosis is made. 5.) Any existing Resident with a newly identified rash will be placed on contact isolation until a diagnosis is made. 6.) In addition to the attending physician, the Medical Director will be informed of any Resident with suspected or confirmed scabies for guidance. MONITORING PROCESS: 1.) Findings from weekly skin sweep will be presented and discuss with QA Committee monthly X's 6 months for review and further recommendations and resolutions.	

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During a telephone interview on 12/2/16 at 4:49 p.m., FM 1 stated initially Resident 2 had a bad rash, then Resident 1 developed a rash and a week after visiting Resident 1, FM 1 had developed a red and itchy rash all over her body and under her breast folds. According to FM 1's Dermatologist report dated 10/5/16, FM 1 had a confirmed case and diagnosis of scabies. On 10/19/15 and 11/2/16 the Dermatology report indicated FM 1 was receiving treatment for scabies.

During an observation on 12/3/16, at 3:46 p.m., the facility's dermatologist was observed performing a skin scrapping to Resident 1's right thigh. MD 1 failed to perform hand washing before and after direct contact.

A review of the facility's policy dated 1/1/12 and titled "Skin and Wound Management" indicated the certified nurse assistants (CNA) will complete body checks on resident's on shower days and report unusual findings to the licensed nurse. Treatments for skin problems, wounds, and non-pressure ulcers will be assessed and documented by a licensed nurse. A licensed nurse will report any changes in the resident's skin condition to the attending physician, Director of Nursing Services (DNS), the interdisciplinary Team (IDT)-skin committee and the responsible party. The licensed nurse will document the status of all skin conditions at least weekly or as otherwise indicated in the resident's care plan, document all notifications following a change in the resident's skin condition and update the resident's care plan as necessary.

b. On 12/2/16 at 8:01 a.m., Resident 2 (Roommate of Resident 1) was observed with a

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2.) Patterns or concerns observed will be discussed with QAA committee for further suggestions and recommendations.

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scattered red rash on the thighs, hands and feet. The resident's right hand and fingers were patchy and white. Resident 2 was observed scratching her left foot, left lower leg and right upper thigh.

A review of the admission record indicated Resident 2 was re-admitted to the facility on 9/21/16 and on 11/25/16 with diagnoses that included cutaneous (skin) abscess (a collection of pus that has built up within the tissue of the body) of left upper limb, rash and other nonspecific skin eruption (outbreak or flare-up).

A review of the MDS dated 8/9/16 indicated Resident 2 had moderately impaired cognition and required limited and one person assistance with activities of daily living.

A review of the physician's history and physical (H & P) for Resident 2 indicated the resident had generalized rashes characterized by dry, itchy patches and crusting on the following dates: 8/2/16, 8/3/16, 8/22/16, 9/8/16, 9/14/16, 9/22/16, 9/25/16 and 10/6/16. According to the H & P dated 10/17/16 the rashes had improved.
A review of Resident 2's physician's orders indicated care and treatment of skin rashes on the following dates:
8/2/16-Triamcinolone 2.5 % cream twice a day to both upper arms for itching.
8/3/16-Triamcinolone 1 % cream twice a day to both upper arms for itching for 30 days
8/3/16- Dermatology consult.
8/7/16- Apply A&D (vitamins A and D-a medicated ointment used to heal diaper/skin rash) cream three times a day and as needed for rashes and itching, diagnosis: contact dermatitis.
8/17/16- Appointment with Dermatologist Dr on 8/31/16 at 9:00 am.

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8/23/16- General body dermatitis apply Triamcinolone 0.1 % cream every other day for 30 days and alternate with Calamine and Praxomine (a topical medication used for itching that have a numbing effect).
9/7/16-Elimite 5 % cream from neck to toes n pm, then shower in the am for prophylaxis repeat in 14 days
9/22/16-Generalized body rashes, apply Fluocinonide (a topical medication used for to relieve itching, redness, dryness, crusting, scaling, inflammation, and discomfort) 0.1% ointment daily for 30 days
10/19/16-Generalized body rashes, apply Triamcinolone 0.1 % ointment on M-W-F, then Fluocinonide 0.5 % ointment on T-TH-S-Sun for 30 days.
11/21/16- Generalized body rashes apply Triamcinolone 0.1 % ointment daily for 30 days
11/22/16- Dermatologist consult related to red bumps all over body.
11/30/16-Generalized body rashes apply Fluocinonide 0.5 % ointment daily for 30 days and Benadryl (medication used to treat allergic reactions) cream daily as needed.

A review of the nurses' admission assessment dated 8/2/16 indicated Resident 2 had generalized body rashes to both arms and hands. An admission assessment dated 9/22/16 indicated Resident 2 had generalized body rashes from the head to the toes. Another admission assessment dated for 11/29/16 indicated that Resident 2 had a generalized dry and scaly rash.
A review of the nurses' notes on the following dates indicated Resident 2:
9/8/16 timed at (3 p.m.-11 p.m.) -Refused Elimite treatment.

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9/9/16 timed at (3 p.m.-11 p.m.)- Refused prophylaxis treatment for suspected scabies
11/21/16 timed at 2 p.m. - The Physician discontinued diphenhydramine (medication that blocks allergic and inflammatory reactions) 25 milligrams (mg) by mouth every 6 hours as needed for itching
11/21/16 at 9 p.m.-Generalized body rashes, improving but not yet resolved.
11/22/16 at 5 p.m.-Had red bumps all over body. physician notified, and dermatologist consult was ordered

The nurses' notes dated from 9/10/16 through 10/31/16, 11/30/16, 12/1/16 and 12/2/16 indicated Resident 2's skin was warm and dry to touch.

A review of the treatment records dated for 8/10/16 indicated Resident 2 had a general body rash characterized by elevated red bumps with complaints of itching. On 8/3/16 through 8/22/16 the resident was treated with Triamcinolone 0.1 % cream twice a day and A&D ointment daily as needed for itching.

On 8/23/16 through 8/30/16 Resident 2 was treated with Triamcinolone 0.1 % cream every other day to the body

A review of the treatment records dated 9/29/16 indicated Resident 2 had generalized, scattered, irritated, red flat skin rashes. According to the treatment record on 10/6/16 the resident's rash was improving well and on 10/13/16 the resident had multiple pinkish/brownish flat rashes.

Resident 2's treatment record dated 11/21/16 through 11/30/16 indicated the resident was treated with Triamcinolone 0.1% ointment daily

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OSAGE HEALTHCARE & WELLNESS CENTRE	1001 SOUTH OSAGE AVE INGLEWOOD, CA 90301

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for generalized body rashes.

A review of a nursing assessment document titled "change of condition" dated 11/22/16 and timed between 3 p.m -11 p.m., indicated Resident 2 had red bumps on the left arm and hip area, and red areas on the left forearm. The resident had no complaints of pain or discomfort and the Dermatologist was consulted. Further review of the nurses notes titled" change of condition" dated 11/24/16 and timed between 3 p.m. - 11 p.m., Resident 2 had red raised spots and was itching.

A review of Resident 2's Surveillance Data Collection Form, completed by the DSD, dated 12/2/16, indicated the resident had no current maculopapular and/or itching rash.

A review of Resident 2 plan of care dated 8/2/16, and titled "At Risk for Skin Break/Ulcer formation" related to history of skin tears/ulcers/chronic dermatitis indicated to administer medication and treatment as ordered and monitor for effectiveness/delayed healing. Provide skin care frequently, obtain lab tests as ordered and monitor for signs and symptoms of infection.

A review of a short term plan of care for Resident 2 titled "Skin Rash" and dated on 8/3/16 with a target date of 9/3/16 indicated the resident's rash will be resolved without complications daily within 30 days. The interventions were to administer treatment as ordered, monitor rash and advise the physician of progress and/or complications Dermatological consultation and follow-up as needed and notify Dermatologist of non-response etc.

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A review of plan of care for Resident 2 titled "Scabies"and dated on 9/7/16 indicted the resident will be free of scabies with intervention that included: provide Elimite 5 % cream from the neck to the toes. Encourage and/or assist the resident with hand washing, check skin daily during care and notify the physician as necessary. Place the resident on contact isolation, wash all clothing and bed linen. Provide education to resident, responsible party and staff regarding special care needs.

A review of another plan of care for Resident 2 dated on 9/22/16, 11/30/16 and titled "Skin-Short Term Non-Pressure Ulcer" for generalized body rashes the goals indicated skin condition will heal within 30 days and the resident will be free from further skin breakdown. The interventions included to administer medication and treatment as ordered and monitor for effectiveness. Provide good skin care and provide education to resident, responsible party and staff regarding special care needs.

A review of another plan of care for Resident 2 titled "Alteration in Skin Integrity: Generalized Rashes to the body" and dated on 12/1/16 had no indicated interventions.

During an observation on 12/3/16, at 3:45 p.m., MD 1 was observed performing Resident 2's skin scrapping to the resident's left hand. MD 1 failed to perform hand washing before and after resident care.

During an interview on 12/1/16 at 1:55 p.m., LVN 4 stated Resident 2 had a generalized rash with red scratches and red bumps all over her body. LVN 4 stated that resident was re-admitted to the

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facility several times and could not recall how long the rash existed. LVN 4 further stated the resident no longer have a rash.

During an interview on 12/1/16 at 3:10 p.m., LVN 3 stated Resident 2 was sent to a GACH for skin evaluation six months ago. When asked of the skin evaluation results, LVN 3 stated "I do not know."
During an interview on 12/2/16 at 8:30 a.m., LVN 3 stated she had performed all treatments on Resident 2 ever since her admission to the facility. LVN 3 stated Resident 2's have a generalized scattered flat red rash all over her body. The resident's hands are patchy and white and improving. LVN 3 stated that no Dermatology consult was conducted due to a disconnected telephone number and the Dermatologist was no longer contracted with the facility.

During an interview on 12/2/16 at 1:55 p.m., LVN 3 provided Resident 2's general acute care hospitals (GACH) dermatological report dated on 1/28/16 which indicated a diagnosis of dermatitis. LVN 3 stated that she should have followed-up on the findings, but did not. LVN 3 further stated she was responsible for performing weekly skin checks/sweeps on all residents and stopped after the prior DON left the facility in July 2016. LVN 3 stated she was offered prophylactic treatment from the prior DON but never used it.

During an interview on 12/2/16 at 2 p.m., the Director of Nurses (DON) stated there was no endorsement regarding scabies during her transition when acquiring the role of the facility's DON.

A review of the facility's 1/1/12 policy and

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procedure titled "Skin and Wound Management" indicated the IDT-Skin Committee would document discussion and recommendations for:
i. Non-pressure ulcers, wounds and other skin conditions that do not respond to treatment.
ii. Non-pressure ulcers, wounds and other skin conditions that worsen or increase in size
iii. Complaints of increased pain, discomfort or decrease in mobility by a resident.
iv. Signs of ulcer sepsis, presence on exudates, odor or necrosis.
v. Residents refusing treatment.

A review of the admission record indicated Resident 3 was admitted to the facility on 8/30/16 with diagnosis which included chronic obstructive pulmonary disease (COPD - a lung disease causing a cough and shortness and breath) and pneumonia (infection of the lungs).

A review of the MDS dated 11/1/16 indicated the resident had no cognitive impairment and required extensive assistance from facility staff in dressing, toileting, and personal hygiene

A review of Resident 3's physician's orders indicated care/treatment on the following dates.
9/7/16 - apply Elimite 5% cream from the neck to the toes in the pm, then shower in am for prophylaxis. Repeat in 14 days.
9/23/16 - Benadryl (medication used to treat sneezing, runny nose, itching and other allergies) 25 milligrams (mg) every 6 hours as needed for itching.
10/19/16 - apply Triamcinolone 0.1% ointment every day for 30 days.
A review of the nurse's admission notes dated 10/18/16 indicated Resident 3's skin was dry/flaking, warm and dry to touch.

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A review of the Non-Pressure Sore Skin Problem Report dated 10/19/16 indicated Resident 3 had scattered, white pinkish/brownish flat generalized body rashes.

A review of the Weekly Skin Progress Report on the following dates indicated:
10/26/16 - Multiple red spots, some brownish old skin from rashes. Improved.
11/2/16 - Improved, less rashes noted
11/10/16 - Resolving
11/15/16 - Resolved

A review of Resident 3's treatment record dated 9/7/16 and 9/22/16 indicated the resident was treated with Elimite 5% cream from the neck to the toes in the evening (pm), then shower in the morning (am) for prophylaxis. Repeat in 14 days

A review of Resident 3's treatment record dated 9/22/16 through 9/30/16 indicated the resident was treated with triamcinolone 0.1% ointment and leave open to air (LOA) every day for generalized multiple white patchy skin.

Resident 3's treatment record dated 10/1/16 through 10/31/16 indicated the resident was treated with triamcinolone 0.1% ointment and LOA every day for generalized multiple white patchy skin.

A review of Resident 3's treatment record dated 10/19/16 indicated the resident had generalized body rashes and perianal irritation

Upon further review there was no treatment record for the month of November 2016 in Resident 3's clinical record.

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A review of Resident 3's Surveillance Data Collection Form, completed by the DSD, dated 12/2/16, indicated the resident had no current maculopapular and/or itching rash.

A review of Resident 3's care plan dated 9/7/16 and titled "Pruritus/Itching" indicated the resident had itching related to an unknown cause. Interventions included assess/observe for itching/persistent rubbing or scratching of the skin, applying emollient creams or ointments frequently to prevent dryness, administer medication/treatment as ordered, report to MD for related changes in condition. Elimite 5% cream one time as prophylaxis.

During an observation on 12/3/16 at 8:55 a.m., LVN 2 was observed giving CNA 6 Elimite 5% cream to apply to Resident s 1, 2, and 3

During an observation on 12/3/16, at 4:05 p.m., the facility's Dermatologist was observed performing skin scrapping on Resident 3's right thigh. The Dermatologist did not perform hand washing before or after direct resident care During an interview on 12/1/16 at 2:45 p.m., Resident 3 stated that she was admitted to the facility in August 2016. The resident stated that she did not have a rash at the time of admission but developed a bumpy rash all over her back, buttocks and body two weeks after admission to the facility, due to Resident 1 who had a rash and was itching "like crazy" and is currently itching Resident 3 stated that she was not in direct contact with Resident 1, however we used the same shower room. Resident 3 further stated that she was treated with two different types of cream and currently using the prescribed cream to her body. The resident stated she requested to be

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seen by a dermatologist and was inquiring about the prescribed body cream, and was told by LVN 3 that the facility's dermatologist will return to the facility next year (2017). Resident 3 stated that she had asked if the facility would check her labs, perform a skin scraping or skin cultures, LVN 3 stated "No." The resident stated that she did not receive any body inspections and continues to have a rash with itching.
During an interview, on 12/1/16, at 3:15 p.m., LVN 3 stated that Resident 3 did not have scabies skin scrapings. LVN 3 stated that Resident 3 had not been seen by a Dermatologist and was aware of the facility's policy indicated to refer to a dermatologist for a skin assessment with a diagnosis of suspected scabies. LVN 3 stated that Resident 3's rash had since resolved and she performed a body check on the resident every shower day.

During an interview on 12/2/16 at 7:40 a.m., LVN 5 stated that she believed that Resident 3 had complaints of a rash but did not have a rash in November 2016. LVN 3 further stated that Resident 3 revealed a rash to her during the night 12/1/16.

During an interview on 12/2/16 at 2:16 p.m., LVN 3 stated that she should have followed-up on the findings, but did not. LVN 3 further stated she was responsible for performing weekly skin checks/sweeps on all residents and stopped after the prior DON left the facility in July 2016. LVN 3 stated she was offered prophylactic treatment from the prior DON but never used it.

During an interview on 12/3/16 at 8:59 a.m., Resident 3 stated she was itchy all over her body.

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During an interview on 12/4/16 at 7:00 p.m., Resident 3 stated she was still itching and cream applied to her body on 12/3/16, which she then showered off.

A review of Resident 4's admission record indicated the resident was re-admitted to the facility on 10/3/15 with diagnosis which included dementia (memory loss) and hypertension (high blood pressure).
A review of the MDS dated 10/27/16 indicated Resident 4 had mild cognitive impairment and required limited assistance with one person physical help in performing activities of daily living (ADLs) such as dressing, toileting, eating, and bathing.
A review of Resident 4's physician's orders indicated care and treatment of skin rashes on the following dates:
9/26/16 - Apply A&D ointment daily to Resident 4's lower legs for two weeks for dry skin.
11/3/16 - Apply Fluocinonide 0.05% ointment daily for three days for a generalized body rash and multiple red spots.
11/22/16 - Dermatologist consult related to red bumps noted all over the body
12/2/16 - Appointment with Dr (Dermatologist) on 12/9/16 at 10:15 a.m.

A review of Resident 4's Nursing Care Notes dated 11/22/16 indicated a call was placed to the MD to notify of red bumps all over the residents body. MD ordered dermatologist consult.

A review of Resident 4's Change of Condition Notes dated 11/22/16 indicated the resident was monitored every shift from 11/23/16 11 p.m.-7 a.m. shift through 11/25/16 7-3 shift for red bumps and marks on the body and lower legs

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A review of the nurses' Weekly Summary for Resident 4 between the following dates: 7/6/16 thru 7/13/16, 7/13/16 thru 7/20/16, 7/20/16 thru 7/27/16, 7/27/16 thru 8/3/16, 8/3/16 thru 8/10/16, 8/10/16 thru 8/17/16, 8/17/16 thru 8/24/16, 8/24/16 thru 8/31/16, 8/31/16 thru 9/7/16, 9/28/16 thru 10/5/16,10/5/16 thru 10/12/16, 10/12/16 thru 10/19/16, 10/19/16 thru 10/26/16, 10/26/16 thru 11/2/16, 11/2/16 thru 11/9/16, 11/9/16 thru 11/16/16, 11/16/16 thru 11/23/16, and 11/23/16 thru 11/30/16 there was no documented skin assessment, but there was a notation to refer to the treatment book.

A review of Resident 4's Treatment Record indicated the resident was treated with A&D ointment to both legs for dryness on 9/26 through 9/30/16.

A review of the Treatment Record indicated Resident 4 was treated with Flucocimide 0.05% ointment and LOA daily from 11/3 through 11/30/16 for generalized body rash with multiple red spots.

A review of Resident 4's Surveillance Data Collection Form, completed by the DSD, dated 12/2/16, indicated the resident had no current maculopapular and/or itching rash.

A review of Resident 4's care plan dated 10/5/15, revised on 10/16, titled "Skin" indicated to administer medication and treatment as ordered and monitor for effectiveness/delayed healing, care and reposition with care rounds, provide activities that allow for skin improvement, provide skin care frequently, and clean resident's skin after each episode of incontinence.

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During a shower observation on 12/2/16 at 1:40 p.m., Resident 4 was observed with a red rash to arms, legs, back, breasts, and stomach.

During an interview on 12/2/16, at 2:16 p.m., LVN 3 stated that she should have followed-up on the findings, but did not. LVN 3 further stated she was responsible for performing weekly skin checks/sweeps on all residents and stopped after the prior DON left the facility in July 2016. LVN 3 stated she was offered prophylactic treatment from the prior DON but never used it.

During an observation on 12/3/16, at 3:55 p.m., MD 1 was observed performing Resident 4's skin scrapping to the resident's left forearm. MD 1 failed to perform hand washing before or after resident contact.

During an observation on 12/4/16, at 1:20 p.m., CNAs 2, 7, and 8 were observed inside Resident 4's room wearing gowns and gloves. CNA's 2, 7, and 8 inquired if they were allowed to step into the hallway to transport the resident to the shower. They stated they never received an in-service and were unaware of the facility's infection control policy and procedures.

During an interview with CNA 2 on 12/2/16 at 1:45 p.m., CNA 2 stated the facility was making her give Resident 4 a shower every day since the end of October for the rash.

During an interview on 12/2/16 at 1:55 p.m., LVN 3 stated Resident 4 had an improved spotted, pink colored rash for a month. LVN 3 stated the resident was not pending dermatology appointment but had received ointment and daily showers.

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A review of the facility's 1/1/12 policy and procedure titled "Skin and Wound Management" indicated the licensed nurse would document the status of all skin conditions at least weekly or as otherwise indicated in the resident's Care Plan and update the resident's Care Plan as necessary.

During a face to face interview on 12/2/16 at 12:30 p.m. CNA 1 stated that she started itching around the first week in October 2016 after caring for Resident 2. CNA 1 stated that she had a rash under her breast over her entire back, both wrist and ankles. Observed two evenly lined discolored red spots on the CNA 1's right wrist. CNA 1 stated that she was informed by LVN 3 that Resident 2 did not have scabies because she had been tested for scabies. However, the previous nurse who cared for Resident 1 had tested positive for scabies.

During an interview on 12/2/16 at 12:55 p.m., CNA 2 stated that she began working at the facility on 9/20/16. Soon after working at the facility, CNA 2 stated that she developed small black spots on her left arm, right wrist, under her breast and was itching badly. The CNA stated that she had assisted CNA 1 with Resident 2 and Resident 4 and believed that she was exposing the rash to the residents.

During an interview on 12/2/16 at 1:20 p.m., CNA 3 stated that she had a "bad" itchy rash over her entire back and was offered a cream for the itching on two separate occasions from the previous Administrator and DON, but had never received the cream for itching.

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During an interview on 12/2/16 at 1:30 p.m., CNA 4 stated that she currently have a rash on her left foot and left arm. CNA 4 stated the previous DON had informed her that Resident 2 had scabies. CNA 4 further stated that her daughter was currently itching

During an interview on 12/2/16 at 8:30 p.m., the facility's newly appointed Dermatologist stated that he had assessed Resident 1, 2, 3, and 4. The residents are approached as having scabies until it is confirmed and a stat (immediate) skin scrapping would be ordered. The facility's Dermatologist further stated the resident's would be placed on contact isolation and skin scrapings would be performed. If the skin scraping results are negative and the resident's skin is worsening or not responding to treatment, a repeat skin scraping would be performed and a skin biopsy

During an interview on 12/3/16 at 9:45 a.m., the DSD stated that she and the DON performed the skin scrapings on Resident 1 and was authorized by the facility's newly appointed Dermatologist to perform skin scrapings on the residents. When asked if she had training or knowledge to perform skin scrapings, the DSD stated that she was trained by the DON only after reading the clinical labs' scabies scraping collection instructions. The DSD further stated that she had never performed a skin scraping prior to 12/2/16.
During an interview on 12/3/16 at 10:12 a.m., the DON stated that she had no formal training on scabies skin scraping. The DON stated that when the scabies skin scraping kits arrived to the facility she did not call the facility's Dermatologist to perform the skin scrapings. The DON further stated that she did not read the facility's policy because there were instructions on scabies skin

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	056143	BUILDING _____ WING _____	C 12/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OSAGE HEALTHCARE & WELLNESS CENTRE	1001 SOUTH OSAGE AVE INGLEWOOD, CA 90301

(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
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scrapings from the lab. When asked about accuracy of scabies skin scraping collection the DON stated that she and the DSD were not trained to perform skin scrapings and would call the lab or the Dermatologist to perform new skin scrapings.

During an interview on 12/3/16 at 3:15 p.m., the facility's newly appointed Dermatologist stated that he had the ability to authorize and/or certify anyone to perform skin scrapings for scabies and had instructed the DON and the DSD to perform skin scrapings on Resident 1, 2, 3 and 4. The Dermatologist was asked how are scabies confirmed, the dermatologist stated mainly by a clinical presentation which included a general or localized rash. The nursing staff scrapped the scaly areas of the skin lesions where the rash was more visible. The Dermatologist further stated a positive skin scraping is indicative of scabies, a negative skin scraping is indicative that the mite was not captured. A skin biopsy would be more accurate for diagnosing scabies.
The facility did not report the suspected cases of scabies to the Department in accordance to the facility's policy and procedure titled, Prevention and Control of Scabies in California Longterm Facilities. The policy notes when there are two or more confirmed cases or one confirmed case and at least two suspected case of scabies it should be reported to the Department.

Because of the facility's failure to ensure and maintain accurate infection control practices and surveillance for Resident 1, 2, 3, and 4, who had a rash for more than 90 days, which was not responding to treatment and had not been seen by a Dermatologist and was not tested for scabies and because the facility's licensed nurses

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LVN 3, who was aware of the skin conditions of the residents failed to follow-up with the Dermatologist, and the because of the facility's failure to follow their policy on prevention and control of scabies, an immediate jeopardy was called on 12/2/16 at 3:22 p.m., with the administrator and the Director of Nurses.

The administrator presented an acceptable plan of correction action to the surveyor on 12/9/16 which consisted of the following:
All six residents identified with rashes on body were immediately placed on presumptive contact isolation precaution on 12/2/16 and will remain on contact isolation precaution until cleared by Dermatologist.
a. In-Services was immediately provided and initiated on 12/2/16 by the DON to direct patient-care staff on 3 p.m. to 11 p.m. shift and will continue to provide a series of in-services with regards to infection control management, placing emphasis on care and management of skin rashes with unknown etiology.
b. In-Service will continue until all staff are captured and completed. No direct-care staff will provide Resident's care until they have been provided in-service.

c. 1:1 in-service training was provided to treatment nurse (LVN) involved on 12/2/16 by the DON Designee in regards to skin care and management, with emphasis on notifying the physician and DON regarding skin rashes not responding to current treatment order.

d. A series of in-services provided by the DON Designee to all staff initiated on 12/2/16, in regards to Skin Care and management, with emphasis on notifying the charge nurse of any

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OSAGE HEALTHCARE & WELLNESS CENTRE	1031 SOUTH OSAGE AVE INGLEWOOD, CA 90301

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Resident with a skin rash.

e. Resident's skin check/sweep initiated and completed on 12/2/16. No other Residents affected.
f. All direct patient-care employees scheduled on 12/2/16 on 3 p.m.-11 p.m. shift were interviewed and assessed for signs/symptoms of rashes. No affected employees reported on 3 p.m.- 11 p.m.
g. Completion of interviews and assessment of all direct patient-care employees completed on 12/5/16. No affected employees reported with symptoms of scabies.
h. DON will make rounds weekly with the Treatment Nurse to review all wounds and skin abnormalities.
i. Treatment Nurse will do skin sweep weekly and any findings of rashes noted on Residents body will be reported to the Infection Control Preventionist for proper identification and management within 24 hours upon identification.
j. Infection Control Preventionist will conduct Surveillance Data Collection for proper identification, interventions and reporting
k. Any newly admitted resident with an undiagnosed rash will be placed on contact isolation until a diagnosis is made.
l. Any existing resident with a newly identified rash will be placed on contact isolation until a diagnosis is made.
m. In addition to the attending physician, the Medical Director will be informed of any resident with suspected or confirmed scabies for guidance.
On 12/9/16 at 12:44 p.m., the administrator and the director of nurses were informed the immediate jeopardy was lifted.

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During an observation, on 12/3/16, at 3:45 p.m., the MD was observed performing skin scrappings on Residents 1, 2, 3, and 4. MD 1 donned but failed to perform handwashing ettiquette before and after contact with each of the residents. The DON provided assistance to MD 1.

A review of the facility's 2/13 policy and procedure titled "Hand Hygiene" indicated for facility staff, visitors, and volunteers must perform hand hygiene procedures in the following circumstances:

A. Wash hands with soap and water
1. Before eating;
2. After using the bathroom;
3. When soilded with visible dirt or debris;
4. After unprotected (ungloved and damaged gloves) contact with blood, other bodily fluids, secretions, excretions, mucous membranes, non-intact skin, intact skin soiled with blood and other body fluids, wound drainage and soiled dressings;
5. After contact with intact and non-intact skin, clothing and environmental surfaces of residents with active diarrhea even if gloves are worn;
6. Before and after food preparation;
7. Before and after assisting residents with dining if direct contact with food is anticipated or occurs.

The facility's policy and procedure further stated hand hygiene is always the final step after

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