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	055199	A. BUILDING _____ B. WING _____	C 05/08/2019

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health Licensing and Certification during an abbreviated standard survey for a Facility Reported Incident (FRI) investigation. Complaint number CA00618814 Representing the California Department of Public Health: Surveyor Federal ID number 39589, HFEN. The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. One deficiency was issued for complaint number CA00618814.	F 000		
F 656 SS=G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and	F 656		5/16/19

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

Electronically Signed | 05/16/2019

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F 656	Continued From page 1 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide physician ordered care and treatment in accordance with professional standards of practice for one of three sampled residents (Resident 1) when Resident 1's right and left hand mittens (device used to cover the hands in an effort to prevent movement of the hands and fingers) were not applied on 1/4/19 as ordered by the physician. The physician order written on 1/2/19 instructed staff to place the hand mittens on both the right and left hands and to continuously monitor to prevent self-extubation	F 656	F656 Care Plan 1. How corrective actions will be accomplished for those residents affected by the deficient practice. The resident 1 expired on [redacted] no corrective action could be accomplished. 2. How the facility will identify other residents having the potential to be affect	

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F 656	Continued From page 2 (removal of the tracheostomy device which is the covering for a surgically created opening in the throat to provide life-sustaining air passage). This failure resulted in Resident 1 removing the tracheostomy device and was found not breathing and without a pulse. Resident 1 was declared dead on [redacted] at 11:30 p.m., 35 minutes after being observed alive, with tracheostomy in place and in her usual condition. Findings: During a review of the clinical record for Resident 1, the Admission Record (document containing resident personal information), undated, indicated Resident 1 was a 61 year-old female admitted to the Skilled Nursing Facility (SNF) on 11/6/15 for diagnoses that included Chronic Respiratory Failure (an on-going condition characterized by the inability of the lungs to adequately provide oxygen into the blood) and Tracheostomy (surgically placed opening in the throat to provide air passage). On 9/18/18, Resident 1 was diagnosed with Anxiety Disorder (a mental health illness characterized by a sudden feeling of panic and fear, restlessness, and uneasiness). During a review of the clinical record for Resident 1, the Progress Notes dated [redacted], at 11:55 p.m., indicated, "[11:30 p.m.] made walking rounds with [night shift] nurse. Resident was found in her bed unresponsive. Resident had removed [tracheostomy] and mitten. Resident appeared cyanotic [skin and lips were bluish color) with pupils fixed [not responsive]. No pulse or respirations were noted. Three RN's [registered nurses] and one LVN [licensed vocational nurse] at bedside aided to assess	F 656	by the same deficient practice and what corrective actions will be taken. DON reviewed all residents in Sub-Acute unit on 5/15/19 for restraints and no other resident had any physician order for restraints or exhibited any behaviors of self-extubating. 3. What Measures will be put in place or what systemic changes will the facility make to ensure the deficient practice does not recur. Facility has ordered soft hand mittens on 5/15/19 and received on 5/16/19, two pairs of soft hand mittens will be stored in a resident's room with physician orders for hand mittens. Two extra pairs of hand mittens will be stored in the linen closet for immediate use and checked weekly by the unit manager. DON in-serviced 41 out of 42 licensed nurses and CNAs on Sub-Acute unit on 1/5/19, 5/10/19 and 5/14/19 regarding the importance of following physician orders, the application and care for hand mittens, and following care plan interventions. 1 Licensed nurse is on maternity leave and will be educated on her return before start of shift. Physician orders for hand mittens will be entered upon receipt by the nurse in the special instructions in care profile and MAR on resident's electronic medical record where its prominently visible to all	

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F 656	Continued From page 3 vitals and resident status. Resident reintubated (tube placed back into the lungs to artificially provide breaths for the patient), suctioned and was provided with 100% oxygen. Interventions were ineffective ... Orders received to ... release body to mortuary." During a review of the clinical record for Resident 1, the Physician Order dated 1/2/19, at 11:14 a.m., indicated, "Monitor R/L [right/left] soft hand mitten restraint. Remove [every] 2 hours for 15 minutes. Wash hands and dry thoroughly before re-applying mitten, assess skin every 2 hours for 30 days [related to] repetitive behaviors of pulling on trach ties, blow by mask [provides oxygen], and Posey [type of restraint] resulting in multiple episodes of self-extubation." During a telephone interview with Certified Nursing Assistant (CNA) 1, on 2/17/19, at 4:19 p.m., he stated Resident 1 had history of restlessness on a daily basis and during her restless periods she would pull out her medical devices [feeding tubes, tracheostomy tube, nephrostomy tubes (inserted into the kidneys)]. CNA 1 stated he observed Resident 1 around 8 p.m. and noted her arms and hands were covered with a bed sheet. CNA 1 stated he had not checked Resident 1's hands to make sure she was wearing her mittens. CNA 1 stated on 1/4/19 before his shift ended at 10:30 p.m., he provided Resident 1 with care and did not observe hand mittens on Resident 1. During a telephone interview with RN 1, on 2/25/19, at 3:31 p.m., RN 1 stated she was assigned to care for Resident 1 on 1/4/19 and was not familiar with Resident 1's care. RN 1 stated 1/4/19 was the second time she was	F 656	licensed nurses. CNA instructions will be entered by the nurse upon receipt of the order into CNA Task Care Record into the when a resident has orders for hand mittens. The CNAs will be documenting in electronic medical records to the visual check that mittens are in place every 2 hours. 4. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. HIM or designee will audit resident profile , MAR, CNA electronic medical record documentation on Physician order/ restraint audit tool monthly to ensure the physician orders, special instructions are in place into a resident's medical record who has physician orders for hand mittens. Medical records audit findings will be shared with IDT and will be reviewed monthly. DON will review audits, correct and report any findings to QAPI committee on a quarterly basis until QAPI committee determines it's no longer necessary.	

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F 656	Continued From page 4 assigned to care for Resident 1. RN 1 stated she was unaware of the physician order written on 1/2/19 to place bilateral hand mittens on Resident 1. RN 1 stated the day shift nurse notified her on 1/4/19 Resident 1 had one hand mitten on and not two hand mittens. RN 1 stated she did not review Resident 1's clinical record before initiating care and was unaware why Resident 1 required hand mittens. RN 1 stated she became aware of the physician orders for Resident 1 to wear left and right hand mittens after Resident 1 had died on [redacted]. RN 1 stated she did not apply or remove Resident 1's hand mitten on 1/4/19. During a telephone interview with RN 1, on 3/6/19, at 3:27 p.m., she stated on 1[redacted] at 10 p.m. she observed one hand mitten on Resident 1's left hand and the right hand without a hand mitten. RN 1 stated at 11:30 p.m. she performed resident rounds (exchange of shift communication of resident information from one nurse to another) with the night shift nurse and found Resident 1 in her bed with her tracheostomy device pulled out, pupils fixed, and without a pulse. RN 1 stated she initialed the physician's order documenting that she provided the ordered treatment. RN 1 stated she did not read the physicians order to apply and remove the bilateral hand mittens. RN 1 stated she did not follow the physician's order for hand mittens. RN 1 stated she should have read the physicians order to ensure Resident 1's bilateral hand mittens were on Resident 1's left and right hands. RN 1 stated she was responsible for following Resident 1's care plan interventions for hand mittens. RN 1 stated she did not follow the care plan interventions to apply and remove Resident 1's bilateral hand mittens.	F 656	5. The facility will be in substantial compliance as of 5/16/19.	

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F 656	Continued From page 5 During an interview with LVN 1, on 4/10/19, at 3:05 p.m., she stated Resident 1 had a history of restlessness and had pulled out her tracheostomy device multiple times. LVN 1 stated the Attending Physician (AP) ordered bilateral hand mittens on 1/2/19 to ensure Resident 1 did not pull out her tracheostomy device. LVN 1 stated Resident 1 had a history of hooking her fingers under the Posey strap and would pull her tracheostomy device out completely. LVN 1 stated when Resident 1 would pull out her tracheostomy nurses would immediately reinsert the tracheostomy device in order for her to breathe. During a concurrent interview and clinical record review with the Director of Nurses (DON), on 4/30/19, at 1:38 p.m., the DON reviewed the Progress Notes and stated the Nursing Notes indicated Resident 1 pulled out her tracheostomy device completely on different occasions dating from 11/8/18 to 1[redacted] for a total of five times. The DON reviewed the Progress Note dated 1/2/19 at 10 a.m. and stated the Nursing Note indicated Resident 1 was having increased restlessness, pulling out the tracheostomy device, and was throwing her legs over the bed. The DON stated Resident 1's behaviors were increasing so the bilateral hand mittens were ordered on 1/2/19 to prevent Resident 1 from pulling out her tracheostomy device. The DON stated the expectation was for the CNA or Licensed Nurse (LN) to apply the bilateral hand mittens if they were not on Resident 1. The DON stated Resident 1 was supervised by the CNA, LN and RT at different times. The DON stated staff were able to go to the linen closet, central supply or laundry to obtain the hand mittens when they were not observed on Resident 1.	F 656		

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F 656	Continued From page 6 During a review of the clinical record for Resident 1, the Progress Notes dated 11/25/18, at 10:10 p.m., indicated, "Entered residents room, resident is agitated pulling on trach [tracheostomy] Posey [one-piece collar helps secure tracheostomy tube around the neck to help prevent removal, extubation of tracheostomy device), gown and enteral feeding tube [provide nutrition to patients who cannot obtain nutrition by mouth, and unable to swallow safely] ..." During a review of the clinical record for Resident 1, the Progress Notes dated 12/15/18, at 3:50 a.m., indicated, "Writer entered resident's room to check on resident, found resident with dislodged trach. Posey and ties were attached to trach ..." During a review of the clinical record for Resident 1, the Progress Notes dated 12/17/18, at 9 p.m., indicated, "Charge nurse went to give medications to resident at [8:30 p.m.], resident's trach was in her left hand, with ties and Posey ..." During a review of the clinical record for Resident 1, the Progress Notes dated 12/20/18, at 9:20 p.m., indicated, "Resident pulled out trach at [9:20 approximately]. Nurse became aware resident had pulled out trach as she was getting ready to administer medication ..." During a review of the clinical record for Resident 1, the Progress Notes dated 12/21/18, at 3:13 a.m., indicated, " ... Writer found resident with Posey and trach ties undone by resident. Trach was still in place ..." During a review of the clinical record for Resident 1, the Progress Notes dated 12/25/18, at 12 p.m.,	F 656		

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indicated, "at [10:30 a.m.] during round, nurse noted trach pulled out ..."

During a review of the clinical record for Resident 1, the Progress Notes dated 12/27/18, at 1:18 p.m., indicated, " ... resident continues pulling on medical devices and ripped off Posey after trach care done ..."

During a review of the clinical record for Resident 1, the Progress Notes dated 12/28/18, at 11:02 a.m., indicated, "At [7:45 a.m.] nurse noted that resident has trach pulled out, her both hands around her neck, resident is itching and seemed restless ..."

During the review of the clinical record for Resident 1, the Progress Notes dated 1/2/19, at 10 a.m., indicated, "Resident is febrile, flushed, has expiratory wheeze, increased restlessness throwing her legs over the bed and repetitive pulling on her trach mask and ties ... [MD 1] visited examined [Resident 1] and ordered ... to apply bilateral hand mittens to avoid pulling her tracheostomy ...."

During an interview with the RT, on 5/1/19, at 7:59 a.m., he stated Resident 1 was taken off the ventilator on 2/8/16 and was left with her tracheostomy device. The RT stated Resident 1 was not connected to a ventilator on 1/4/19. The RT stated when Resident 1 pulled out her tracheostomy device it needed to be reinserted in less than two minutes. The RT stated Resident 1's plan was to continue to have her tracheostomy device to help her breathe.

During an interview with the AP, on 5/1/19, at 8:50 a.m., he stated the expectation of the staff at

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the skilled nursing facility was for the mittens to be on as ordered for Resident 1's protection.

During an interview with LVN 2, on 5/1/19, at 10:05 a.m., she stated she was familiar with Resident 1's care. LVN 2 stated she was unaware Resident 1 required bilateral hand mittens and was not provided the information during report. LVN 2 stated bilateral hand mittens were ordered because Resident 1 had extubated herself multiple times. LVN 2 stated on 1/3/19 and 1/4/19 she cared for Resident 1, and Resident 1 did not have bilateral hand mittens on 1/3/19 or 1/4/19. LVN 2 stated she realized bilateral hand mittens were ordered when she looked at the Medication Administration Record (MAR). LVN 2 stated on 1/4/19 she went to look for a mitten in the utility room and was unable to locate another mitten for Resident 1 and stated she did not place the mittens on Resident 1, because her husband was at bedside. LVN 2 stated she notified RN 1 she needed to locate another mitten to apply to Resident 1.

During a review of the clinical record for Resident 1, the Physical Restraint Assessment dated 1/2/19, at 11:15 a.m. indicated, "TYPE OF PHYSICAL RESTRAINT 1. Hand Mitt... REASON FOR PHYSICAL RESTRAINT 8. Pulls at feeding/ [intravenous]/other tubes... 1B Medical justification for restraint. r/t [related to] repetitive behaviors of pulling on trach ties, blow by mask and Posey resulting in multiple episodes of self extubation."

During a review of the clinical record for Resident 1, the Care Plan dated 1/2/19, indicated, "I use r/l soft hand mitten physical restraints r/t repetitive behaviors or pulling on trach ties, blow by mask,

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and Posey resulting in multiple episodes of self extubation... Interventions/Tasks... Monitor R/L soft hand mitten restraint. Remove [every] 2 hours for 15 minutes. Wash hands and dry thoroughly before re-applying mitten, assess skin."

During a review of the clinical record for Resident 1, the Progress Notes dated 1/3/19, at 11:28 a.m., indicated, "IDT (interdisciplinary team- a group of health care professionals who work in a coordinated fashion toward a common goal for the patient) met and discussed the resident's multiple self extubations. Resident experiences restlessness and anxiety, pulls on her tubing and trach ties... The IDT is in agreement for the use of hand mittens... to avoid further extubation."

During a review of the clinical record for Resident 1, the Death Certificate dated 1/9/19, indicated, "IMMEDIATE CAUSE (A) CARDIOPULMONARY ARREST (B) PNEUMONIA, ETIOLOGY UNKNOWN, (C) CHRONIC RESPIRATORY FAILURE ..."

Review of the facility policy and procedure titled, "Care Plans" dated 11/24/17, indicated, "The resident's care plan is to be reviewed and revised by the IDT after resident's initial assessment, quarterly, and more often as warranted by the changes in a resident's condition.... The focus/problem list is to identify those areas that the resident has actual or potential risk for injury, illness and other impairments... Each goal is to be realistic, measurable, directed towards the focus and individualized to the resident. The goal is to build upon the resident's strength... Interventions are those services, items and approaches that specific staff is to carry out to aid the resident in

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F 656	Continued From page 10 attaint and maintaining their highest functional level and preventing further decline." Review of the "Lippincott Manual of Nursing Practice" 10th Edition dated 2014, page 16-17 indicated, " Standards of practice General Principles... 1 b. These standards provide patients with a means of measuring the quality of care they receive. Common Departures from the Standards of Nursing Care... failure to follow physician's orders..."	F 656		