Acceptable POC ec 12/17/14

PRINTED: 12/10/2014
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555398	A. BUILDING _____ B. WING _____	C 11/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR POST ACUTE CARE CENTER OF HAYWARD	25919 GADING ROAD HAYWARD, CA 94544

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F 000	INITIAL COMMENTS The following represents the findings of the California Department of Public Health during the investigation of a complaint. Complaint Number: CA00412764 Representing the Department: 15335 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.	F 000	**"Preparation and/or execution of this plan of correction, does not constitute admission or agreement by the provider, of the truth of the facts alleged or the conclusions set forth in this statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Health and Safety code section 1280 and 42CFR et seq".** **This Plan of Correction constitutes the facility's credible allegation of compliance.**	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that one of one sampled residents (1) had trimmed fingernails and gloves on to keep the resident from repeatedly scratching herself resulting in an avoidable hospitalization for intravenous antibiotics for periorbital cellulitis (infection of skin tissues) caused by Resident 1 repeatedly scratching the skin around the right eye. Resident 1 had the behavior of scratching herself repeatedly and this was addressed in her care home and day treatment program by the	F 309	**1.How Corrective Action will be accomplished for residents affected:** Resident was discharged on 09/30/2014. However, the following plan of correction was implemented post the complaint visit for the resident's length of stay and would have been managed with the following approaches:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Adm — (X6) DATE: 12/10/14

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 309	Continued From page 1 application of gloves, Caregiver 1 brought in the gloves to the facility but facility refused to use them and Resident 1's fingernails were long and jaggered. Findings: Record review on 9/28/14 showed Resident 1 was first admitted to the facility on 6/20/14 from the acute care hospital after she was treated for reourrent aspiration pneumonia (infection of the lungs caused by breathing in of food, liquids or saliva) with respiratory failure. She had a gastrostomy tube for feeding of formula into the stomach and was sent to the facility for continued antibiotic treatment for her aspiration pneumonia. Prior to hospitalization Resident 1 had been in a care home According to the readmission minimum data set assessment dated 7/16/14, Resident 1, had the diagnoses of, anxiety disorder, generalized muscle weakness, and unspecified intellectual disabilities (Rett syndrome a neurodevelopmental disorder, characterized by slowing of development, loss of purposeful use of the hands, which is followed by compulsive hand movements such as wringing and washing). She was totally dependent for all of her activities of daily living, her lower extremities (hip, knee, ankle, foot) were impaired but she had no impairment of her upper extremities (shoulder, elbow, wrist, hand). She had cognitive impairments with no long or short term memory, and had no ability to understand others or make herself understood. She was fed through a tube inserted into her abdomen. (Rett syndrome ref. http://www.ninds.nih.gov/disorders/rett/detail_rett.htm)	F 309	1. Nail care was provided to the resident to provide smooth clean nails. 2. A meeting or phone conference would have been held with the Case Manager and Care giver from the care home or other person who had specific knowledge of her individualized care needs. **2.Identification of Residents with the Potential to be Affected:** 1. All residents who can not provide their own nail care and have a cognitive deficit that would potentially cause them to harm themselves with their fingernails have the potential to be affected. 2. All resident's nails were checked and nail care was provided by all C.N.A.s on their assignment if needed. This was verified by the DON and DSD by 12/01/2014. **3. Measures to Prevent Recurrence:**	

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F 309	Continued From page 2 A care plan was developed on 7/7/24 to focus on her problem of ADL self care deficit with interventions to check nail length and trim and clean on bath day and as necessary, and the resident requires full staff participation with bathing, bed mobility, personal hygiene, dressing, eating and transferring from one surface to another. There was another care plan developed on 7/7/14 with a focus of, the resident used anti-anxiety medications for anxiety that was manifested by yelling and screaming. The interventions were to give the anti-anxiety medication as ordered and monitor for side effects, and to assess for possible cues of pain or discomfort if the resident yelled or screamed. There were no other non medicine interventions developed. According to a nurses note written on 8/20/14 at 8:07 a.m. Resident 1 was yelling and scratched her face. The medication administration record revealed that she had been given Lorazepam (anti-anxiety drug) solution 0.5 milliliters (ml) on 8/20/14 at 5:04 a.m. A progress note written on 8/20/14 at 10:15 a.m. by a visiting RN from the acute care hospital who was monitoring the resident's progress at the facility revealed, "Pt (patient) reportedly had an 'outburst' and scratched her face...Pt. advocate (care giver from outside day treatment program, (CG 1)) at the bedside today, Reports that Pt. does seem more agitated since arriving at facility..." The nurses continued to document the monitoring of Resident 1's scratch marks on her face in	F 309	1. If patient admitted has a relationship with East Bay Regional Center, DON will contact case manager from Regional Center and request a copy of Resident's Individual Service Plan (ISP) to coordinate the care. 2. Upon admission each resident will be evaluated to determine if nail care needed. Nail care will be provided upon admission if needed and a podiatry referral will be completed. . After that each Sunday will be a nail care day – both finger nails and toe nails will be checked and service provided and a Podiatry Referrals List will be created for those who need Podiatry. The facility contracted podiatrist visits once or twice per month. If resident's have an emergent need, an appointment will be scheduled by social services with the podiatrist. 3. DSD has re-educate CNAs and Licensed Nurses on facility's nail care practice on 11/26/2014.	

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F 309	Continued From page 3 notes dated 8/21/14 at 10:57 p.m., with yelling and screaming noted on 8/22/14 at 4:00 a.m. for which she received a dose of Lorazepam. There was an Interdisciplinary Team (IDT) note dated 8/22/14 at 9:52 a.m. which revealed that the resident had a tendency to rub/scratch her face when she gets agitated which probably caused the scratch marks. The plan of care (POC) was to continue to monitor scratch marks on the face and notify the doctor (MD) for any significant changes or signs and symptoms of infection, keep fingernails short and well-trimmed...re-direct resident's behavior of yelling and restlessness. Turn on TV, talk and use gently touch for comfort. A review of the medical record did not reveal that nail care had been provided to the resident or that any measures to prevent the resident from scratching herself, such as placing gloves on her hands, were tried. The resident received Lorazepam for anxiety on on 8/22/14 at 12:30 p.m. and the MD's order was changed from every eight hours to every six hours the medicine could be given for increasing anxiety. On 8/23/14 at 1:52 a.m. the nurses noted one episode of agitation, kept yelling and screaming...pain medication was given but still yelling...Antianxiety medication given with good effect. Scratch mark on face. By 4:06 p.m. on 8/23/14 the nurses noted that they called the MD to notify him of the Resident's right eye swelling. "Resident has a tendency to scratch/rub her face when she gets agitated which possibly caused the swelling on the site. Good eye care rendered. Will continue to monitor." The nurses noted the resident was, "Still noted with facial swelling.	F 309	**4. Monitoring Corrective Action and Responsibility:** 1. Manager of the Day will do weekly checks on Sunday to ensure that Nail Care took place. 2. During Room Rounds department heads will also check resident's nail care and report to DON and DSD during Morning Stand Up. Trends will be reported to the QAPI Committee for recommendation and follow-up. **Date of compliance** 12/19/2014	12/19/14

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F 309	Continued From page 4 Monitor for any signs of complication." at 11:10 p.m. that night. On 8/24/14 at 4:17 a.m. the resident received another dose of Lorazepam for yelling and screaming. At 10:04 p.m. on 8/24/14 the nurse's note revealed that the resident was "Still with swelling on right periorbital (around the eye) area." and she was started on antibiotic eye ointment. On 8/25/14 at 4:15 a.m. the resident received a dose of Lorazepam for yelling and screaming. On 8/25/14 the nurses note revealed that the resident was noted with right eye surrounding area red, swollen, warm to touch unable to open no drainage noted. She vomited once and had a fever of 101.3 degrees Fahrenheit. The MD ordered for the resident to be transported to the hospital via ambulance. The History and Physical Report from the acute care hospital dated 8/25/14 revealed that the resident had a temperature of 102 degrees Fahrenheit, associated with vomiting, eye swelling, and increasing agitation. The resident was given a CT scan of the head and neck which suggested periobital cellulitis (An infection of the eyelid or skin around the eye which can occur after a scratch, or injury around the eye, which allows germs to enter the wound...). (http://www.nlm.nih.gov/medlineplus/ency/article/000976.htm) The resident was discharged from the hospital on 9/2/14 and sent back to the facility. According to the transfer summary , Resident had the diagnosis of periorbital cellulitis secondary to methicillin-resistant Staphylococcus aureus, also	F 309		

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F 309	Continued From page 5 known as MRSA which is a skin bacteria that has developed a resistance to methicillin type antibiotics such as penicillin. She was treated with intravenous antibiotics with an infectious disease consultation. She was to continue oral antibiotics upon discharge for the next seven days. During an on-site visit to the facility on 9/23/14 at 10:45 a.m., Resident 1 was observed lying in bed with her outside community based care giver at her side. The resident' s finger nails were extended over the finger tips and the right thumb nail was long and jagged. She had two hand mitts, which were large padded mittens used to restrain movement of the fingers, at the bed side by the caregiver (CG stated that she took the mittens off the resident. She stated that when Resident 1 was first admitted to the facility she brought in her gloves that she wore at her care home that was used to prevent her from scratching herself, but the facility told CG 1 that they couldn't use them because they were considered "restrictive." With the gloves, according to CG 1, Resident 1 could still move her fingers but not scratch her skin. In an interview on 9/23/14 at 11:15 a.m. Resident 1's certified nursing assistant (CNA 1) stated that the resident was supposed to receive nail care on Sundays and since she did not work the past Sunday, she did not know when the last time Resident 1 had her nails cut. During an on-site visit to the facility on 11/3/14 at 1 p.m., the Director of Nurses (DON) stated that the facility had not contacted Resident 1's intermediate care facility or the day treatment program that sent CG 1 daily to work with	F 309		