STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **675743**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **05/20/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OCEANVIEW HEALTHCARE AND REHABILITATION	**519 NINTH AVE N TEXAS CITY, TX 77590**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0224

Level of harm - Immediate jeopardy

Residents Affected - Some

Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on observation, interview and record review the facility failed to develop and implement their policy that prohibited mistreatment and neglect of one of five residents (Resident #1) reviewed for care provided.

Weekly skin assessments were not being conducted by licensed staff on all residents to identify skin issues. On 5/1/15, a necrotic area with slough was identified on Resident #1's left shin. Resident #1 was transferred to the hospital where several open areas were identified on his buttocks. Resident #1's last skin asssessment dated 4/28/15 did not identify either of the areas and the facility staff were not treating these areas.

LVN #1 did not use aseptic technique when providing wound care to the recent [MEDICAL CONDITION] incision of Resident #1 who
had a compromised medical condition of [MEDICAL CONDITION].

An IJ was identified on 5/18/2015. While the IJ was removed on 5/20/2015 the facility remained out of compliance at a scope of isolated and a severity level of actual harm.

This failure affected one resident who required an emergency leg [MEDICAL CONDITION] and placed eight residents with wounds at risk of wounds deteriorating due to poor wound care or new wounds not being treated due to inadequate or lack of skin assessments. These failures could cause the residents to have a rapid decline in health due to a serious infection.

Findings include:

Intake # 8

Record review of Resident #1's face sheet revealed a [AGE] year old male admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. Resident #1 was transferred to the hospital on [DATE] and readmitted to the facility on [DATE].

Record review of Resident #1's MDS dated [DATE] revealed the resident was moderately impaired for cognition and was at risk of developing pressure ulcers, required supervision for personal hygiene and was occasionally incontinent of bladder. The MDS identified Resident #1 as using a wheelchair for mobility.

Record review of Resident #1's care plan dated 4/14/14 revealed Resident #1 was at risk for an ADL self-deficit related to dementia. Goal was to maintain current level of function, grooming and personal hygiene, approaches includes: 1-2 staff for bathing, is able to turn and reposition in bed,, allow sufficient time for dressing and undressing, able to hold cup, feed self, eat finger foods independently, able to bear weight , pivot, use arms to support, and take two steps for transfers .

Further record review of Resident #1's care plan dated 9/18/14 revealed Resident #1 was resistive to care related to dementia. Goal was the resident will co-operate with care through the next review date of 7/20/15.

Record review of Resident #1's care plan dated 1/19/15 revealed Resident #1 had a diabetic ulcer to his left lateral ankle measuring 6.4cm by 3.0 cm by 0.2 cm with no maceration related to vascular insufficiency. Goal was ulcer will improve by 7/20/15. Approaches outlined included: wound care consult, document progress of healing on an on-going basis, notify MD as indicated, monitor/document /report to MD any signs of infection, green drainage, foul odor and treat wound daily.

Record review of Resident #1's TAR dated May 2015 revealed: cleanse left lateral foot with normal saline, pat dry, apply santyl ointment and silver alginate daily. The order was dated 4/21/15.

Record review of Resident #1's last weekly skin assessment dated [DATE] revealed Resident #1 had a left lateral ankle venous ulcer only. No other areas were noted on the assessment.

Record review of Resident #1 nurses' notes dated 5/1/15 at 11:16 a.m., revealed documentation by the treatment nurse that during wound care this am, noted patient to have new area to left shin, 100 % slough noted. Called DON to assess. During assessment DON noted purulent drainage and very foul odor. Call placed to MD to notify of transfer to ER.

Record review of Resident #1's nurses' notes revealed late entry documentation by DON dated 5/3/15 at 1:39 p.m., treatment nurse notified DON of open area to left shin. Upon assessment noted area approximately 12.7 cm by 13.5 cm with slough in the center approximately 12.0 cm by 13.1 cm. Copious amount of purulent drainage with foul odor. Not able to palpate femoral, popliteal or pedal pulse. Resident denied pain. 2+ [MEDICAL CONDITION] to left lower extremity. Notified MD with orders received to send resident to ER.

Record review of Resident #1's hospital physical examination dated 5/1/15 revealed, a [AGE] year old male with history of [MEDICAL CONDITION], presents to ER today [MEDICAL CONDITION] and wet Gangrene of the left lower extremity of unknown
etiology. Review also revealed Resident #1 had multiple white plaques on shaft of penis, and multiple small area of skin breakdown on posterior buttocks. The hospital documents revealed the resident did not know how long the wound on the left shin had been there and the resident was unkempt and appeared not to have had personal care for a period of time. Further review of the record revealed a plan of an emergent below knee amputation due [MEDICAL CONDITION].

Observation on 5/2/15 at 1:00 p.m., Resident #1 at the hospital revealed he was alert and oriented, and responded to asked questions appropriately. Left below knee amputation was noted with stomp wrapped. Resident #1 had long and dirty fingernails with a buildup of a black substance underneath the nails. He had a grown and untrimmed beard. His skin was dry and appeared unkempt. The resident was in the intensive care unit for continuous observation.

Interview on 5/2/15 at 1:00 p.m., Resident #1 said he was transferred to the hospital yesterday and the doctors removed his left lower leg due to some infection and poor circulation. He said he received wound care to his left lateral ankle daily at the facility.

Interview on 5/3/15 at 1:40 p.m., the DON said the treatment nurse performed daily dressing change to the venous ulcer on Resident #1's left lateral ankle. She explained the area found on 5/1/15 was new according to the treatment nurse. The DON said she interviewed the treatment nurse who reported it was the first time she saw the area despite new necrotic area was on Resident #1's left shin with a foul odor. The DON said the facility, after this discovery, had performed skin assessments on all at risk residents and staff training was initiated immediately to ensure prompt reports and notifications of skin issues. The DON reported inconsistencies were identified with written documentation of wound measurements, and locations . The facility treatment Nurse resigned immediately after the discrepancies were identified.

Attempts made to interview the treatment nurse on 5/2/2015 and 5/3/2015 were not successful. She did not answer the phone when called and did not return calls when message left.

Interview on 5/3/15 at 3:00 p.m., the facility Corporate Nurse said the treatment nurse was hired a couple of weeks prior to the above incident and was given adequate training prior to her duty resumption. She expressed the treatment nurse had resources available for her if she was in doubt or unsure of her findings. she explained the previous DON was responsible for monitoring and evaluating the treatment Nurse's performance and wound management . The Corporate nurse explained the current DON had been in the facility for just a few days and would be responsible for the monitoring or over seeing the wound care, nurse's training and competence of skills verifications.

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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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OCEANVIEW HEALTHCARE AND REHABILITATION	**519 NINTH AVE N** **TEXAS CITY, TX 77590**

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F 0224

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 1)
Record review of an in-service attendance record dated 5/3/15 by the DON revealed in part the following program content which included instruction that weekly skin assessments were to be completed by the charge nurse and documented in the computer. The CNA ' s were to utilize the shower sheets to identify all open areas, sign the shower sheet, notify the charge nurse immediately, and turn the shower sheet into the DON. The nurse was to review the shower sheets, follow-up with documentation/communication the CNA has informed you of. Once the shower sheet had been evaluated by the nurse it was to be signed and submitted to the DON.
Interview on 5/14/15 at 9:40 A.M. the DON stated she had two ADON ' s and they were to complete the weekly head to toe skin assessments on all residents not identified as having skin issues. She said she had recently hired a new treatment nurse who started today (5/14/15) and she would be responsible for the skin assessments on those residents with identified wounds.
Observation of wound care for Resident #1 on 5/14/15 at 10:10 A.M. revealed LVN #1 gloved without hand hygiene prior to starting wound care. LVN #1 had her clean supplies on wax paper and she placed them on the resident ' s bed. She removed and discarded the old dressing from the resident ' s left lower extremity surgical wound site and the dressing was soiled with drainage. In removing one dressing it was somewhat adhered to the resident ' s skin and LVN #1 picked up a clean gauze from the supplies on the resident ' s bed and placed the gauze under the wound and poured a small amount of normal saline over the old gauze to loosen it so it could be removed without pulling on the resident ' s skin. She then used the gauze that was under the wound to cleanse around the resident ' s wound. LVN #1 picked up another gauze, moistened it with normal saline and cleansed the wound several times with the same gauze. She repeated this two more times. LVN #1 changed gloves without performing hand hygiene in between glove changes and picked up and placed clean dressing over the incision. She retrieved a package of soft (kling) gauze from her pocket, opened it and wrapped the dressing to the hold it in place. She did this twice. LVN #1 then gathered the dirty dressings in a red plastic bag as well as the remaining clean supplies and took them out of the room. She did not wash her hands until prompted by the treatment nurse. She took the bottle of normal saline out of the resident ' s room and replaced it in her medication cart.
In an interview with LVN #1 immediately after the treatment she stated she had worked in Hospice services for a number of years prior to working at the facility and had not had to perform wound care in a number of years. She was unable to identify any issues with the way the treatment was performed. She said she had no wound care training and no in-services on wound care, performing treatments or performing skin assessments in the past two weeks.
Interview on 5/14/15 at 10:50 A.M. ADON #1 stated she had not received any instruction on a plan for the ADON ' s to complete weekly head-to-toe skin assessments and she had not completed any.
Interview on 5/14/15 at 2:30 P.M. the DON stated she had spoken to the wound care physician who was in the facility at the time and he was going to observe the treatment nurse perform wound care and he would evaluate her performance. She said the wound care physician also stated he would conduct an in-service for the nursing staff on wound care and the DON would need to contact his office to schedule a date. The DON stated she was not aware of any competencies for nursing staff for wound and skin treatments. She also stated LVN #1 would not be doing any more treatments until she had been checked off by her or one of the corporate wound care nurses. The DON stated she would have all of the skin assessments done on everyone by 5/16/15.
Record review on 5/18/2015 revealed there were 32 residents on the 3rd floor. There were 9 residents identified with wounds/skin issues. Continued review with the DON revealed there were 23 residents who had not received a head to toe skin assessment the week of 5/3-5/9 and the week of 5/10-5/16/15. There were 3 residents documented as a refusal for skin assessment and 4 residents with no skin assessment documented for May 2015.
Interview with the DON on 5/18/15 at 10:00 A.M. the DON did not have a response as to why skin assessments had not been consistently done on residents for the past two weeks. She stated she was aware every resident in the facility was to have a skin assessment done after the incident with Resident #1 and she thought the ADON ' s were doing them. She stated she should have followed up to make sure all of the assessments were done. The DON said the corporate nurse would be doing in-servicing and competencies for all nursing staff. She said the corporate nurse was wound care certified.
Record review of facility's policy on Resident Rights dated 5/2007 revealed that the employees of the facility would take action to protect and prevent neglect from occurring by having knowledge of the individual resident's care needs.
An IJ was identified and the Administrator was notified on 5/18/2015 at 12:10 P.M. A Plan of Removal (POR) was submitted and accepted on 5/19/2015. The IJ was removed on 5/20/2015. The POR included:
Systemic Change to Prevent Re-Occurrence
1. A full skin assessment on 100% of the residents was initiated on 5/18/15 at 1:00 pm to identify any resident with wounds that facility was not previously aware of. DON, ADONs, treatment nurse and RN resource nurse are participating in the skin assessment. At conclusion of skin assessment, any new wound issues will be reported to resident ' s attending physician by treatment nurse, DON or ADONs. Care plans for new wounds will be updated immediately to reflect current skin status and interventions.
2. All licensed nurses will be in-serviced by RN Resource (corporate consultant nurses) and LVN WCC (Wound Care Certified) on wound care assessment, treatment and policy by 5-19-15. No nurse will be allowed to assess or do a treatment until in-service and treatment competency checklist is completed. In-service will include the guidelines from the NPUAP (National Pressure Ulcer Advisory Panel) as referenced in F314 in the SOM, support surfaces, and turning and repositioning based on assessment.
3. A competency check to be completed on Treatment Nurse, weekend Treatment Nurse, DON, ADONs, day and evening nurses by 5:00p 5/18/15. All other licensed nurses to be completed by 12 noon on 5-19-15. Competency check will be conducted by a LVN from sister facility who is Wound Care Certified. Nurses who do not pass competency check will be retrained, then competency rechecked. Nurses who cannot pass competency checks will not be allowed to assess skin or do wound treatment.
4. As of 5/18/2015, upon admission, each resident will have skin assessment conducted by facility designated treatment nurse. The LVN WCC (Wound Care Certified) from sister facility will in-service treatment nurse to conduct skin assessment upon admission.
5. As of 5/18/2015, for residents identified with current wounds; weekly measurement and observation/assessment will be completed by the Treatment Nurse rounding with Wound Physician. Attending physicians will be contacted for residents ' wounds that are not showing progress toward healing.
6. As of 5/18/2015, weekly head to toe skin assessment will be conducted on all residents by the treatment nurse. For any resident identified with a new wound issue, physician and family will be notified.
7. As of 5/18/2015, CNAs will observe any skin issues observed during resident showers. A resident shower sheet will be completed by CNAs and given to charge nurses to initiate wound assessment. CNAs will be in-serviced by DON and ADONs on skin shower observations to be completed by 5-19-15. Residents who refuse shower will be offered bed bath by CNA, at which time skin assessment with licensed nurse will be completed. If a resident consistently refuses to shower and bathe in bed, nursing administration, their physician and their RP will be notified. Their Care Plan will be updated to reflect their refusal. The social worker will be notified to setup a care plan meeting with the RP.
8. As of 5/18/2015 and ongoing, DON and/or ADON will ensure daily treatments are occurring per order by direct observation of all wound treatments/and or dressing until compliance with facility treatment procedure. TARs will be printed and placed in QA binder for DON and/or ADON to initial after monitoring observation has occurred. Weekend Treatments observation/monitoring will be assigned and rotated with DON, and ADONs, until compliance with facility treatment procedures is achieved.
9. As of 5/18/2015 and ongoing, DON and/or ADON will review new Admissions with 24 hours of admission to ensure wound assessment completed per policy.
10. As of 5/18/2015, Treatment nurse will prepare weekly skin report with list of all residents with current wounds by site/stage. The report will go to the DON for review
Monitoring of the POR:
Record review of the facility ' s skin assessment, shower/bathing observations, completing/documentation on shower sheets, wound care and staff competency checks in-services dated 5/19/15 through 5/20/15 revealed about 95 % of facility nursing staff including CNAs, MAs, LVNs, RNs, and Weekend Supervisors on three of three shifts were in-serviced. LVNs and RNs had received competency checks from wound care certified nurse.
Interviews on 5/20/15 revealed 25 nursing staffs on two of three shifts were interviewed on shower/bathing observations,

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F 0224

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 2)
completing shower/bathing sheets, notifying charge nurse/DON of care refusal, skin assessment and documentation, and wound care/documentation of treatment. All staff members interviewed had been in-serviced and were able to identify the protocols implemented.

Record review of Resident #1's skin assessment was updated as well as skin assessment for all residents on both 200 and 300 halls this was completed on 5/19/15 and 5/20/15.
Record review of Resident #1's care plan as well as all residents with wounds and skin issues were updated on 5/19/15 through 5/20/15.
Observations on 5/20/15 at 8:30AM revealed Resident #1 was in his room eating breakfast; left below knee stomp was wrapped. Resident #1 had follow -up appointment on 5/21/15. Resident #1 expressed no negative concerns.
Record review of the facility's policy on skin assessment not dated revealed the facility will assess all residents upon admission, when a comprehensive assessment is required , quarterly thereafter to identify risk of skin breakdown. All resident will be assessed for skin risk using a pressure ulcer risk assessment form (Braden, Norton or facility specific) within 24 hours of the time of admission by a licensed nurse. Residents will be re-assessed for skin when a comprehensive assessment is requires and quarterly and thereafter. Nursing and dietary will monitor dietary intake and weight patterns on an ongoing basis to identify residents at risk for malnutrition and skin breakdown. The care plan will be updated and implemented based on the needs identified by the comprehensive assessments the and score on the pressure ulcer risk assessment form.
Record review of the facility's policy on skin inspection ,shower day not dated revealed this facility will identify any pertinent skin issues with residents during routine inspection of residents at shower/bath times. CNAs will document all skin issues that he/she observes on the resident as the resident ' s shower, tub or bed bath is given. CNAs will document these issues using the skin assessment -shower form. DON signs off on the form.
Record review on 5/20/2015 of 100% of the resident's records revealed all had skin assessments conducted between 5/18/2015 and 5/20/2015.
Observations on 5/20/2015 of sampled residents on both floors revealed accurate skin assessments documented.
Observation of wound care on 5/ 5 by new treatment nurse revealed good infection control technique.
The Administrator was informed on 5/20/2015 at 11:57 A.M. that the IJ was lowered after verification of the POR implementation had occurred. While the IJ was lowered on 5/20/2015, the facility remained out of compliance at a scope of isolated and a severity level of actual harm. The facility was continuing to monitor and train staff on skin assessments and wound care.
The DON reported there were eight residents with wounds .

F 0309

Level of harm - Immediate jeopardy

Residents Affected - Some

Provide necessary care and services to maintain the highest well being of each resident
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on observation, interview and record review the facility failed to provide care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being for one of five residents (Resident #1) reviewed for care provided.
Weekly skin assessments were not being conducted by licensed staff on all resident to identify skin issues. On 5/1/15, a necrotic area with slough was identified on Resident #1's left shin. Resident #1 was transferred to the hospital where several open areas were identified on his buttocks. Resident #1's last skin assessment dated [DATE] did not identify either of the areas and the facility staff were not treating these areas.
LVN #1 did not use aseptic technique when providing wound care to the recent [MEDICAL CONDITION] incision of Resident #1 who
had a compromised medical condition of [MEDICAL CONDITION].
An IJ was identified on 5/18/2015. While the IJ was removed on 5/20/2015 the facility remained out of compliance at a scope of isolated and a severity level of actual harm.
This failure affected one resident who required an emergency leg [MEDICAL CONDITION] and placed eight residents with wounds at risk of wounds deteriorating due to poor wound care or new wounds not being treated due to inadequate or lack of skin assessments. These failures could cause the residents to have a rapid decline in health due to a serious infection.
Findings include:
Intake # 8
Record review of Resident #1 ' s face sheet revealed a [AGE] year old male admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. Resident #1 was transferred to the hospital on [DATE] and readmitted to the facility on [DATE].
Record review of Resident #1's MDS dated [DATE] revealed the resident was moderately impaired for cognition and was at risk of developing pressure ulcers, required supervision for personal hygiene and was occasionally incontinent of bladder. The MDS identified Resident #1 as using a wheelchair for mobility.
Record review of Resident #1's care plan dated 4/14/14 revealed Resident #1 was at risk for an ADL self-deficit related to dementia. Goal was to maintain current level of function, grooming and personal hygiene, approaches includes: 1-2 staff for bathing, is able to turn and reposition in bed,, allow sufficient time for dressing and undressing, able to hold cup, feed self, eat finger foods independently, able to bear weight , pivot, use arms to support, and take two steps for transfers .
Further record review of Resident #1's care plan dated 9/18/14 revealed Resident #1 was resistive to care related to dementia. Goal was the resident will co-operate with care through the next review date of 7/20/15.
Record review of Resident #1's care plan dated 1/19/15 revealed Resident #1 had a diabetic ulcer to his left lateral ankle measuring 6.4cm by 3.0 cm by 0.2 cm with no maceration related to vascular insufficiency. Goal was ulcer will improve by 7/20/15. Approaches outlined included: wound care consult, document progress of healing on an on-going basis, notify MD as indicated, monitor/document /report to MD any signs of infection, green drainage, foul odor and treat wound daily.
Record review of Resident #1 ' s Physician order [REDACTED].
Record review of Resident #1's TAR dated May 2015 revealed: cleanse left lateral foot with normal saline, pat dry, apply santyl ointment and silver alginate daily. The order was dated 4/21/15.
Record review of Resident #1 ' s last weekly skin assessment dated [DATE] revealed Resident #1 had a left lateral ankle venous ulcer only. No other open skin areas were noted on the assessment.
Record review of Resident #1's nurses' notes dated 5/1/15 at 11:16 a.m., revealed documentation by the treatment nurse that during wound care this am, noted patient to have new area to left shin, 100 % slough noted. Called DON to assess. During assessment DON noted purulent drainage and very foul odor. Call placed to MD to notify of transfer to ER.
Record review of Resident #1's nurses' notes revealed late entry documentation by DON dated 5/3/15 at 1:39 p.m., treatment nurse notified DON of open area to left shin. Upon assessment noted area approximately 12.7 cm by 13.5 cm with slough in the center approximately 12.0 cm by 13.1 cm. Copious amount of purulent drainage with foul odor. Not able to palpate femoral, popliteal or pedal pulse. Resident denied pain. 2+ [MEDICAL CONDITION] to left lower extremity. Notified MD with orders received to send resident to ER.
Record review of Resident #1's hospital physical examination dated 5/1/15 revealed, a [AGE] year old male with history of [MEDICAL CONDITION], presents to ER today [MEDICAL CONDITION] and wet Gangrene of the left lower extremity of unknown
etiology. Review also revealed Resident #1 had multiple white plaques on shaft of penis, and multiple small area of skin breakdown on posterior buttocks. The hospital documents revealed the resident did not know how long the wound on the left shin had been there and the resident was unkempt and appeared not to have had personal care for a period of time. Further review of the record revealed a plan of an emergent [MEDICAL CONDITION] due [MEDICAL CONDITION].
Observation on 5/2/15 at 1:00 p.m., Resident #1 at the hospital revealed he was alert and oriented, and responded to asked questions appropriately. Left below knee amputation was noted with stomp wrapped. Resident #1 had long and dirty fingernails with a buildup of a black substance underneath the nails. He had a grown and untrimmed beard. His skin was dry and appeared unkempt. The resident was in the intensive care unit for continuous observation.
Interview on 5/2/15 at 1:00 p.m., Resident #1 said he was transferred to the hospital yesterday and the doctors removed his left lower leg due to some infection and poor circulation. He said he received wound care to his left lateral ankle daily at the facility.
Interview on 5/3/15 at 1:40 p.m., the DON said the treatment nurse performed daily dressing change to the venous ulcer on Resident #1's left lateral ankle. She explained the area found on 5/1/15 was new according to the treatment nurse. The DON

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F 0309

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 3)
said she interviewed the treatment nurse who reported it was the first time she saw the area despite new necrotic area was on Resident #1's left shin with a foul odor. The DON said the facility, after this discovery, had performed skin assessments on all at risk residents and staff training was initiated immediately to ensure prompt reports and notifications of skin issues. The DON reported inconsistencies were identified with the Treatment Nurse ' s written documentation of the left foot ' s wound measurements and even the location. The facility Treatment Nurse resigned immediately after the discrepancies were identified.
Attempts made to interview the treatment nurse on 5/2/2015 and 5/3/2015 were not successful. She did not answer the phone when called and did not return calls when message left.
Interview on 5/3/15 at 3:00 p.m., the facility Corporate Nurse said the treatment nurse was hired a couple of weeks prior to the above incident and was given adequate training prior to her duty resumption. She expressed the treatment nurse had resources available for her if she was in doubt or unsure of her findings. she explained the previous DON was responsible for monitoring and evaluating the treatment Nurse's performance and wound management. The Corporate nurse explained the current DON had been in the facility for just a few days and would be responsible for the monitoring or over seeing the wound care, nurse's training and competence of skills verifications.
Record review of an in-service attendance record dated 5/3/15 by the DON revealed in part the following program content which included instruction that weekly skin assessments were to be completed by the charge nurse and documented in the computer. The CNA ' s were to utilize the shower sheets to identify all open areas, sign the shower sheet, notify the charge nurse immediately, and turn the shower sheet into the DON. The nurse was to review the shower sheets, follow-up with documentation/communication the CNA has informed you of. Once the shower sheet had been evaluated by the nurse it was to be signed and submitted to the DON.
Interview on 5/14/15 at 9:40 A.M. the DON stated she had two ADON ' s and they were to complete the weekly head to toe skin assessments on all residents not identified as having skin issues. She said she had recently hired a new treatment nurse who started today (5/14/15) and she would be responsible for the skin assessments on those residents with identified wounds. She stated Resident #1 returned to the facility on [DATE].
Observation of wound care to the stump for Resident #1 on 5/14/15 at 10:10 A.M. revealed LVN #1 gloved without hand hygiene prior to starting the wound care. LVN #1 had her clean supplies on wax paper and she placed them on the resident ' s bed. She removed and discarded the old dressing from the resident ' s left lower extremity surgical wound site and the dressing was soiled with drainage. In removing one dressing it was somewhat adhered to the resident ' s skin and LVN #1 picked up a clean gauze from the supplies on the resident ' s bed and placed the gauze under the wound and poured a small amount of normal saline over the old gauze to loosen it so it could be removed without pulling on the resident ' s skin. She then used the gauze that was under the wound to cleanse around the resident ' s wound. LVN #1 picked up another gauze, moistened it with normal saline and cleansed the wound several times with the same gauze. She repeated this two more times. LVN #1 changed gloves without performing hand hygiene in between glove changes and picked up and placed clean dressing over the incision. She retrieved a package of soft (kling) gauze from her pocket, opened it and wrapped the dressing to the hold it in place. She did this twice. LVN #1 then gathered the dirty dressings in a red plastic bag as well as the remaining clean supplies and took them out of the room. She did not wash her hands until prompted by the treatment nurse. She took the bottle of normal saline out of the resident ' s room and replaced it in her medication cart.
In an interview with LVN #1 immediately after the treatment she stated she had worked in Hospice services for a number of years prior to working at the facility and had not had to perform wound care in a number of years. She was unable to identify any issues with the way the treatment was performed. She said she had no wound care training and no in-services on wound care, performing treatments or performing skin assessments in the past two weeks.
Interview on 5/14/15 at 10:50 A.M. ADON #1 stated she had not received any instruction on a plan for the ADON ' s to complete weekly head-to-toe skin assessments and she had not completed any.
Interview on 5/14/15 at 2:30 P.M. the DON stated she had spoken to the wound care physician who was in the facility at the time and he was going to observe the treatment nurse perform wound care and he would evaluate her performance. She said the wound care physician also stated he would conduct an in-service for the nursing staff on wound care and the DON would need to contact his office to schedule a date. The DON stated she was not aware of any competencies for nursing staff for wound and skin treatments. She also stated LVN #1 would not be doing any more treatments until she had been checked off by her or one of the corporate wound care nurses. The DON stated she would have all of the skin assessments done on everyone by 5/16/15.
Record review on 5/18/2015 revealed there were 32 residents on the 3rd floor. There were 9 residents identified with wounds/skin issues. Continued review with the DON revealed there were 23 residents who had not received a head to toe skin assessment the week of 5/3-5/9 and the week of 5/10-5/16/15. There were 3 residents documented as a refusal for skin assessment and 4 residents with no skin assessment documented for both of the two weeks in May.
Interview with the DON on 5/18/15 at 10:00 A.M. the DON did not have a response as to why skin assessments had not been consistently done on residents for the past two weeks. She stated she was aware every resident in the facility was to have a skin assessment done after the incident with Resident #1 and she thought the ADON ' s were doing them. She stated she should have followed up to make sure all of the assessments were done. The DON said the corporate nurse would be doing in-servicing and competencies for all nursing staff. She said the corporate nurse was wound care certified.
Record review of facility's policy on Resident Rights dated 5/2007 revealed that the employees of the facility would take action to protect and prevent neglect from occurring by having knowledge of the individual resident's care needs.
An IJ was identified and the Administrator was notified on 5/18/2015 at 12:10 P.M. A Plan of Removal (POR) was submitted and accepted on 5/19/2015. The IJ was removed on 5/20/2015. The POR included:
Systemic Change to Prevent Re-Occurrence
1. A full skin assessment on 100% of the residents was initiated on 5/18/15 at 1:00 pm to identify any resident with wounds that facility was not previously aware of. DON, ADONs, treatment nurse and RN resource nurse are participating in the skin assessment. At conclusion of skin assessment, any new wound issues will be reported to resident ' s attending physician by treatment nurse, DON or ADONs. Care plans for new wounds will be updated immediately to reflect current skin status and interventions.
2. All licensed nurses will be in-serviced by RN Resource (corporate consultant nurses) and LVN WCC (Wound Care Certified) on wound care assessment, treatment and policy by 5-19-15. No nurse will be allowed to assess or do a treatment until in-service and treatment competency checklist is completed. In-service will include the guidelines from the NPUAP (National Pressure Ulcer Advisory Panel) as referenced in F314 in the SOM, support surfaces, and turning and repositioning based on assessment.
3. A competency check to be completed on Treatment Nurse, weekend Treatment Nurse, DON, ADONs, day and evening nurses by 5:00p 5/18/15. All other licensed nurses to be completed by 12 noon on 5-19-15. Competency check will be conducted by a LVN from sister facility who is Wound Care Certified. Nurses who do not pass competency check will be retrained, then competency rechecked. Nurses who cannot pass competency checks will not be allowed to assess skin or do wound treatment.
4. As of 5/18/2015, upon admission, each resident will have skin assessment conducted by facility designated treatment nurse. The LVN WCC (Wound Care Certified) from sister facility will in-service treatment nurse to conduct skin assessment upon admission.
5. As of 5/18/2015, for residents identified with current wounds; weekly measurement and observation/assessment will be completed by the Treatment Nurse rounding with Wound Physician. Attending physicians will be contacted for residents ' wounds that are not showing progress toward healing.
6. As of 5/18/2015, weekly head to toe skin assessment will be conducted on all residents by the treatment nurse. For any resident identified with a new wound issue, physician and family will be notified.
7. As of 5/18/2015, CNAs will observe any skin issues observed during resident showers. A resident shower sheet will be completed by CNAs and given to charge nurses to initiate wound assessment. CNAs will be in-serviced by DON and ADONs on skin shower observations to be completed by 5-19-15. Residents who refuse shower will be offered bed bath by CNA, at which time skin assessment with licensed nurse will be completed. If a resident consistently refuses to shower and bathe in bed, nursing administration, their physician and their RP will be notified. Their Care Plan will be updated to reflect their refusal. The social worker will be notified to setup a care plan meeting with the RP.
8. As of 5/18/2015 and ongoing, DON and/or ADON will ensure daily treatments are occurring per order by direct observation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **675743**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **05/20/2015**
NAME OF PROVIDER OF SUPPLIER **OCEANVIEW HEALTHCARE AND REHABILITATION**		STREET ADDRESS, CITY, STATE, ZIP **519 NINTH AVE N TEXAS CITY, TX 77590**	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 4) of all wound treatments/and or dressing until compliance with facility treatment procedure. TARs will be printed and placed in QA binder for DON and/or ADON to initial after monitoring observation has occurred. Weekend Treatments observation/monitoring will be assigned and rotated with DON, and ADONs, until compliance with facility treatment procedures is achieved. 9. As of 5/18/2015 and ongoing, DON and/or ADON will review new Admissions with 24 hours of admission to ensure wound assessment completed per policy. 10. As of 5/18/2015, Treatment nurse will prepare weekly skin report with list of all residents with current wounds by site/stage. The report will go to the DON for review Monitoring of the POR: Record review of the facility ' s skin assessment, shower/bathing observations, completing/documentation on shower sheets, wound care and staff competency checks in-services dated 5/19/15 through 5/20/15 revealed about 95 % of facility nursing staff including CNAs, MAs, LVNs, RNs, and Weekend Supervisors on three of three shifts were in-serviced. LVNs and RNs had received competency checks from wound care certified nurse. Interviews on 5/20/15 revealed 25 nursing staffs on two of three shifts were interviewed on shower/bathing observations, completing shower/bathing sheets, notifying charge nurse/DON of care refusal, skin assessment and documentation, and wound care/documentation of treatment. All staff members interviewed had been in-serviced and were able to identify the protocols implemented. Record review of Resident #1' s skin assessment was updated as well as skin assessment for all residents on both 200 and 300 halls this was completed on 5/19/15 and 5/20/15. Record review of Resident #1' s care plan as well as all residents with wounds and skin issues were updated on 5/19/15 through 5/20/15. Observations on 5/20/15 at 8:30AM revealed Resident #1 was in his room eating breakfast; left below knee stomp was wrapped. Resident #1 had follow -up appointment on 5/21/15. Resident #1 expressed no negative concerns. Record review of the facility's policy on skin assessment not dated revealed the facility will assess all residents upon admission, when a comprehensive assessment is required , quarterly thereafter to identify risk of skin breakdown. All resident will be assessed for skin risk using a pressure ulcer risk assessment form (Braden, Norton or facility specific) within 24 hours of the time of admission by a licensed nurse. Residents will be re-assessed for skin when a comprehensive assessment is requires and quarterly and thereafter. Nursing and dietary will monitor dietary intake and weight patterns on an ongoing basis to identify residents at risk for malnutrition and skin breakdown. The care plan will be updated and implemented based on the needs identified by the comprehensive assessments the and score on the pressure ulcer risk assessment form. Record review of the facility's policy on skin inspection ,shower day not dated revealed this facility will identify any pertinent skin issues with residents during routine inspection of residents at shower/bath times. CNAs will document all skin issues that he/she observes on the resident as the resident ' s shower, tub or bed bath is given. CNAs will document these issues using the skin assessment -shower form. DON signs off on the form. Record review on 5/20/2015 of 100% of the resident's records revealed all had skin assessments conducted between 5/18/2015 and 5/20/2015. Observations on 5/20/2015 of sampled residents on both floors revealed accurate skin assessments documented. Observation of wound care on 5/ 5 by new treatment nurse revealed good infection control technique. The Administrator was informed on 5/20/2015 at 11:57 A.M. that the IJ was lowered after verification of the POR implementation had occurred. While the IJ was lowered on 5/20/2015, the facility remained out of compliance at a scope of isolated and a severity level of actual harm. The facility was continuing to monitor and train staff on skin assessments and wound care. The DON reported there were eight residents with wounds.
F 0312 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Assist those residents who need total help with eating/drinking, grooming and personal and oral hygiene.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to provide the necessary services to maintain good grooming and personal hygiene for four of five residents (Resident #1, #2, # 4 and #5) who were reviewed for activities of daily living (ADL) care. -Resident # 1 was not provided fingernail care and was not shaved. -Resident #2 was not provided fingernail, toenail care and his mustache was not trimmed. -Resident #4 and #5 were not provided fingernail care. These failures affected four residents and placed 81 residents at risk of not having their hygiene and grooming needs met which could cause a psychological and medical decline. Findings include: Intake # 8 Resident #1 Record review of Resident #1's face sheet revealed a [AGE] year old male admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #1's MDS dated [DATE] revealed the resident was moderately impaired for cognition, required supervision for personal hygiene and was occasionally incontinent of bladder. Record review of Resident #1's care plan dated 4/14/14 revealed Resident #1 was at risk for an ADL self-deficit related to dementia. Goal was to maintain current level of function, grooming and personal hygiene. Further record review of Resident #1's care plan dated 9/18/14 revealed resident was resistive to care related to dementia. Goal was the resident will co-operate with care through the next review date of 7/20/15. Interview at the hospital on [DATE] at 1:00 p.m., Resident #1 said he was brought to the hospital yesterday and he lost his left leg due to some infection and poor circulation. He said he would like to have his fingernails trimmed and cleaned. He said the nails had been that way for a while now. Resident #1 said he needed little assistance with personal hygiene. Observation at the hospital on [DATE] at 1:00 p.m., revealed Resident #1 alert and oriented, and able to respond to asked questions. A left below knee amputation was noted with the stomp wrapped. Resident #1 had long and dirty fingernails with a buildup of a black substance underneath the nails. He had a grown and untrimmed beard. His skin was dry and appeared unkempt. Resident # 2 Record review of Resident #2's face sheet revealed a [AGE] years old male admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #2's MDS dated ,[DATE]/ 2015 revealed the resident was severely impaired for cognition and dependent on staff for all ADLs. Record review of Resident #2's care plan, not dated, revealed the resident was total dependent on two staff for all ADLs. Observation on 5/2/15 at 2:40 p.m., revealed the resident was curled up in bed with a [DEVICE] feeding being administered. Resident was alert but disoriented. He was noted with long and chipped fingernails and toenails, Resident #2 was unkempt, and his mustache was untrimmed, long and into his mouth. His mustache had dried secretions on it. Interview at the time of the observation, RN #1 said the resident's nails were long and should be trimmed. She explained nail care for non-diabetic residents were performed by aides or nurses while diabetic resident's nails were done by the Podiatrist. Resident #4 Record review of Resident #4' s face sheet revealed an [AGE] year old male admitted on [DATE]. [DIAGNOSES REDACTED]. Record review of Resident #4's MDS dated [DATE] revealed the resident was moderately impaired for cognition requiring extensive assistance with ADLs.

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NAME OF PROVIDER OF SUPPLIER **OCEANVIEW HEALTHCARE AND REHABILITATION**		STREET ADDRESS, CITY, STATE, ZIP **519 NINTH AVE N TEXAS CITY, TX 77590**	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0312 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) Observation on 5/2/15 at 2:30 p.m., revealed Resident #4 in bed. His fingernails were long, there were brown stains all over his fingers and nails. Resident #5 Record review of Resident #5's face sheet revealed a [AGE] year old male admitted on [DATE]. [DIAGNOSES REDACTED]. Record review of Resident #5's MDS dated [DATE] revealed the resident was severely impaired for cognition and dependent on staff for all ADLs. Observation on 5/2/15 at 1:50 p.m., revealed Resident #5 was by the common area. He was disoriented but alert. Resident #5's finger nails on both hands long and untrimmed. His fingernails had a build-up of a dark substance underneath the tips of the fingernails. Interview on 5/2/15 at 3:00 p.m., LVN #1 said the residents should be groomed daily and as needed. She explained nail care was part of personal hygiene and grooming and should be provided daily to dependent residents. Interview on 5/2/15 at 1:50 p.m., CNA#1 said the aides were responsible for daily groomng of the residents . She said this was done daily and when needed. CNA # 1 said the aides can shave the residents but only trimmed nails for non-diabetic residents. She explained if a resident refused care, she would notify the charge nurse. Interview on 5/3/15 at 2:10 p.m., the DON said she was a new employee and was in the process of identifying systems for improvement. Record review of the facility's policy on ADL dated 11/2007 revealed residents who are unable to carry out activities of daily living will receive necessary services to maintain grooming personal and oral hygiene. Facility census dated 5/2/15 revealed 85 residents.
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Be administered in an acceptable way that maintains the well-being of each resident .** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews the administration failed to manage the facility in a manner that enabled it to use the facility ' s resources effectively to maintain the highest practicable physical well-being of 1 of 32 residents (Resident #1) who were reviewed for having the highest physical and mental well-being because of the effective management of the facility. The Administrator failed to supervise the DON and assist with the development and implementation of effective policies and procedures on identifying skin issues for all residents. The Administrator failed to supervise the DON on ensuring staff were trained on performing accurate weekly skin assessments, the correct and timely identification of skin issues, performing wound care and procedures to follow when a resident refused care. The DON failed to verify all staff were competent in performing skin assessments and wound care. The DON failed to train staff on what steps to take when a resident refused care. An IJ was identified on 5/18/2015. While the IJ was removed on 5/20/2015 the facility remained out of compliance at a scope of isolated and a severity level of actual harm. This failure affected one resident who required an emergency leg [MEDICAL CONDITION] and placed eight residents with wounds at risk of wounds deteriorating due to poor wound care or new wounds not being treated due to inadequate or lack of skin assessments. These failures could cause the residents to have a rapid decline in health due to a serious infection. Findings include: Intake # 8 Record review of Resident #1's face sheet revealed a [AGE] year old male admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. Resident #1 was transferred to the hospital on [DATE] and readmitted to the facility on [DATE]. On 5/1/15, a necrotic area approximately 12.7 cm by 13.5 cm with 100 % slough was identified on Resident #1's left shin. Resident #1 also developed multiple open areas on his buttocks which the facility were not treating. The area had purulent drainage with a foul odor. Resident #1 was transferred to the hospital where an emergency [MEDICAL CONDITION] was performed on the left lower leg. Interview on 5/19/15 at 9:50 A.M. the Administrator stated he was not aware there were issues with skin assessments not being conducted on residents. He stated he found out about the incident with Resident #1 after the resident went to the hospital. He stated that was when he also found out the treatment nurse was not doing her job. He said this had not been identified as a problem prior to the issue with Resident #1 and therefore was not part of QA. He stated he trusted the DON to ensure staff were working within their job descriptions and performing their duties as expected. He said when he was told by the DON on 5/15/15 by e-mail all the assessments were completed he did not follow-up to ensure they had been done. He said he did not want to micro-manage the staff. He also said he would make sure to be more involved in holding managers accountable by asking more questions, following up with department heads on issues discussed at morning meetings and make more frequent rounds to discuss issues with staff on the units. Interview on 5/3/15 at 1:40 p.m., the DON said the treatment nurse performed daily dressing change to the venous ulcer on Resident #1's left lateral ankle. She explained the area found on 5/1/15 was new according to the treatment nurse. The DON said she interviewed the treatment nurse who reported it was the first time she saw the area despite new necrotic area was on Resident #1's left shin with a foul odor. The DON said the facility, after this discovery, had performed skin assessments on all at risk residents and staff training was initiated immediately to ensure prompt reports and notifications of skin issues. The DON reported inconsistencies were identified with written documentation of wound measurements, and locations . The facility treatment Nurse resigned immediately after the discrepancies were identified. Record review of an in-service attendance record dated 5/3/15 by the DON revealed in part the following program content which included instruction that weekly skin assessments were to be completed by the charge nurse and documented in the computer. The CNA ' s are to utilize the shower sheets to identify all open areas, sign the shower sheet, notify the charge nurse immediately, and turn the shower sheet into the DON. The nurse is to review the shower sheets, follow-up with documentation/communication the CNA has informed you of. Once the shower sheet had been evaluated by the nurse it was to be signed and submitted to the DON. Interview on 5/14/15 at 9:40 A.M. the DON stated she had two ADON ' s and they were to complete the weekly head to toe skin assessments on all residents not identified as having skin issues. She said she had recently hired a new treatment nurse who started today (5/14/15) and she would be responsible for the skin assessments on those residents with identified wounds. Interview on 5/14/15 at 10:50 A.M. ADON #1 stated she had not received any instruction on a plan for the ADON ' s to complete weekly head-to-toe skin assessments and she had not completed any. Interview on 5/14/15 at 2:30 P.M. the DON stated she had spoken to the wound care physician who was in the facility at the time and he was going to observe the treatment nurse perform wound care and he would evaluate her performance. She said the wound care physician also stated he would conduct an in-service for the nursing staff on wound care and the DON would need to contact his office to schedule a date. The DON stated she was not aware of any competencies for nursing staff for wound and skin treatments. The DON stated she would have all of the skin assessments done on everyone by 5/16/15. Record review on 5/18/2015 revealed there were 32 residents on the 3rd floor. There were nine residents identified with wounds/skin issues. Continued review with the DON revealed there were 23 residents who had not received a head to toe skin assessment the week of 5/3-5/9 and the week of 5/10-5/16/15. There were three residents documented as a refusal for skin assessment and 4 residents with no skin assessment documented for May 2015. Interview with the DON on 5/18/15 at 10:00 A.M. the DON did not have a response as to why skin assessments had not been consistently done on residents for the past two weeks. She stated she was aware every resident in the facility was to have a skin assessment done after the incident with Resident #1 and she thought the ADON ' s were doing them. She stated she should have followed up to make sure all of the assessments were done. The DON said the corporate nurse would be doing in-servicing and competencies for all nursing staff. She said the corporate nurse was wound care certified. Interview on 5/18/15 at 10:30 A.M. the Administrator stated he did not know there was a problem with the skin assessments. He stated he was aware of the issues surrounding Resident #1 and all residents were to have a head-to-toe skin assessment and he was informed by the DON that it had all been taken care of. He further stated the company had plenty of resources to assist Administration and nursing. Interview on 5/19/15 at 10:40 A.M. the DON stated she had directed the ADON ' s to complete the head-to toe assessments for

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NAME OF PROVIDER OF SUPPLIER **OCEANVIEW HEALTHCARE AND REHABILITATION**	STREET ADDRESS, CITY, STATE, ZIP **519 NINTH AVE N** **TEXAS CITY, TX 77590**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0490

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 6)
residents on the second and third floor but she did not follow-up to make sure it was completed. She further stated she did not have a specified plan or timeline on which residents to assess and assumed the task would be completed. The DON stated she should have made sure the skin assessments were done as well as competencies to ensure staff were able to perform the tasks. She further stated there were resources available sure as regional resources, staff at sister facilities to ask for ideas and suggestions, physicians and the medical director.
An IJ was identified and the Administrator was notified on 5/18/2015 at 12:10 P.M. A Plan of Removal (POR) was submitted and accepted on 5/19/2015. The IJ was removed on 5/20/2015. The POR included:
Systemic Change to Prevent Re-Occurrence
1. A full skin assessment on 100% of the residents was initiated on 5/18/15 at 1:00pm to identify any resident with wounds that facility was not previously aware of. DON, ADONs, treatment nurse and RN resource nurse are participating in the skin assessment. At conclusion of skin assessment, any new wound issues will be reported to resident ' s attending physician by treatment nurse, DON or ADONs. Care plans for new wounds will be updated immediately to reflect current skin status and interventions.
2. All licensed nurses will be in-serviced by RN Resource (corporate consultant nurses) and LVN WCC (Wound Care Certified) on wound care assessment, treatment and policy by 5-19-15. No nurse will be allowed to assess or do a treatment until in-service and treatment competency checklist is completed. In-service will include the guidelines from the NPUAP (National Pressure Ulcer Advisory Panel) as referenced in F314 in the SOM, support surfaces, and turning and repositioning based on assessment.
3. A competency check to be completed on Treatment Nurse, weekend Treatment Nurse, DON, ADONs, day and evening nurses by 5:00p 5/18/15. All other licensed nurses to be completed by 12 noon on 5-19-15. Competency check will be conducted by a LVN from sister facility who is Wound Care Certified. Nurses who do not pass competency check will be retrained, then competency rechecked. Nurses who cannot pass competency checks will not be allowed to assess skin or do wound treatment.
4. As of 5/18/2015, upon admission, each resident will have skin assessment conducted by facility designated treatment nurse. The LVN WCC (Wound Care Certified) from sister facility will in-service treatment nurse to conduct skin assessment upon admission.
5. As of 5/18/2015, for residents identified with current wounds; weekly measurement and observation/assessment will be completed by the Treatment Nurse rounding with Wound Physician. Attending physicians will be contacted for residents ' wounds that are not showing progress toward healing.
6. As of 5/18/2015, weekly head to toe skin assessment will be conducted on all residents by the treatment nurse. For any resident identified with a new wound issue, physician and family will be notified.
7. As of 5/18/2015, CNAs will observe any skin issues observed during resident showers. A resident shower sheet will be completed by CNAs and given to charge nurses to initiate wound assessment. CNAs will be in-serviced by DON and ADONs on skin shower observations to be completed by 5-19-15. Residents who refuse shower will be offered bed bath by CNA, at which time skin assessment with licensed nurse will be completed. If a resident consistently refuses to shower and bathe in bed, nursing administration, their physician and their RP will be notified. Their Care Plan will be updated to reflect their refusal. The social worker will be notified to setup a care plan meeting with the RP.
8. As of 5/18/2015 and ongoing, DON and/or ADON will ensure daily treatments are occurring per order by direct observation of all wound treatments/and or dressing until compliance with facility treatment procedure. TARs will be printed and placed in QA binder for DON and/or ADON to initial after monitoring observation has occurred. Weekend Treatments observation/monitoring will be assigned and rotated with DON, and ADONs, until compliance with facility treatment procedures is achieved.
9. As of 5/18/2015 and ongoing, DON and/or ADON will review new Admissions with 24 hours of admission to ensure wound assessment completed per policy.
10. As of 5/18/2015, Treatment nurse will prepare weekly skin report with list of all residents with current wounds by site/stage. The report will go to the DON for review
Monitoring of the POR:
Record review of the facility ' s skin assessment, shower/bathing observations, completing/documentation on shower sheets, wound care and staff competency checks in-services dated 5/19/15 through 5/20/15 revealed about 95 % of facility nursing staff including CNAs, MAs, LVNs, RNs, and Weekend Supervisors on three of three shifts were in-serviced. LVNs and RNs had received competency checks from wound care certified nurse.
Interviews on 5/20/15 revealed 25 nursing staffs on two of three shifts were interviewed on shower/bathing observations, completing shower/bathing sheets, notifying charge nurse/DON of care refusal, skin assessment and documentation, and wound care/documentation of treatment. All staff members interviewed had been in-serviced and were able to identify the protocols implemented.

Record review of Resident #1 ' s skin assessment was updated as well as skin assessment for all residents on both 200 and 300 halls this was completed on 5/19/15 and 5/20/15.
Record review of Resident #1 ' s care plan as well as all residents with wounds and skin issues were updated on 5/19/15 through 5/20/15.
Observations on 5/20/15 at 8:30AM revealed Resident #1 was in his room eating breakfast; left below knee stomp was wrapped. Resident #1 had follow -up appointment on 5/21/15. Resident #1 expressed no negative concerns.
Record review of the facility's policy on skin assessment not dated revealed the facility will assess all residents upon admission, when a comprehensive assessment is required , quarterly thereafter to identify risk of skin breakdown. All resident will be assessed for skin risk using a pressure ulcer risk assessment form (Braden, Norton or facility specific) within 24 hours of the time of admission by a licensed nurse. Residents will be re-assessed for skin when a comprehensive assessment is requires and quarterly and thereafter. Nursing and dietary will monitor dietary intake and weight patterns on an ongoing basis to identify residents at risk for malnutrition and skin breakdown. The care plan will be updated and implemented based on the needs identified by the comprehensive assessments the and score on the pressure ulcer risk assessment form.
Record review of the facility's policy on skin inspection ,shower day not dated revealed this facility will identify any pertinent skin issues with residents during routine inspection of residents at shower/bath times. CNAs will document all skin issues that he/she observes on the resident as the resident ' s shower, tub or bed bath is given. CNAs will document these issues using the skin assessment -shower form. DON signs off on the form.
Record review of 100% of the residents records revealed all had skin assessment completed between 5/18/2015 and 5/20/2015
Observation of sampled residents on both floors revealed accurate skin assessments documented.
Observation of wound care by the new treatment nurse on 5/20/2015 revealed good infection control technique.
The Administrator was informed on 5/20/2015 at 11:57 A.M. that the IJ was lowered after verification of the POR implementation had occurred. While the IJ was lowered on 5/20/2015, the facility remained out of compliance at a scope of isolated and a severity level of actual harm. The facility was continuing to monitor and train staff on skin assessments and wound care.
Refer to F224 and F30 for additional evidence.
The DON reported there were eight residents with wounds.