STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056399	A. BUILDING ______ B. WING _____	**03/27/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KINDRED NURSING AND REHABILITATION-YGNACIO VALLEY	**1449 YGNACIO VALLEY ROAD WALNUT CREEK, CA 94598**

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 0314 **Level of harm -** Actual harm **Residents Affected -** Few	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and medical record reviews, the facility failed to prevent the development of pressure ulcers and did not identify and provide treatment for [REDACTED]. This failure resulted in harm for Resident 1, who developed pressure ulcers on the left leg, foot, and heel; and the right leg, foot, heel, and ankle and delayed getting treatment. Findings: Definitions: 1. Pressure ulcer-injury to skin and/or underlying tissue as a result of prolonged pressure, usually over a bony prominence. 2. Heel footdrop boots- used to prevent skin breakdown, usually worn for two hours on then two hours off. Review of Resident 1's facility medical record Progress Notes, Admission Summary, dated 11/05/16, indicated Resident 1's [DIAGNOSES REDACTED]. Review of the Weekly Pressure Ulcer BWAT (Bate-Jensen Wound Assessment Tool-used to assess and monitor healing of all types of wounds) Report indicated only one wound (sacral) was identified on admission to the skilled nursing facility. Resident 1 was sent to the hospital on [DATE] for chest pain. A review of the hospital record, on 3/24/17, titled, Initial Wound evaluation/consult, dated 12/6/16 at 10:30 a.m., by the Emergency Department (ED) nurse, indicated multiple pressure ulcers were present upon the removal of the heel footdrop boots (medical device to reduce pressure) and socks. The ED nurse noted the wounds with measurements: Left lateral leg DTI (deep tissue injury) 5 by 1.5 cm (centimeters) some blistering (fluid-filled pocket on the skin), Left heel (lateral-side) DTI, 2 by 1.5 cm, evolving and beginning to open, Left heel (plantar-bottom) 4 by 3 cm (old dry), Left foot (lateral) DTI 9 x 4.5 cm with open weeping area in mid foot, green/serous drainage, culture sent (to determine if infected) feels soft; Right heel 2 by 2.5 cm, eschar (dark, dead leathery tissue) dry, unstageable (unable to determine depth of damage due to covering of dead tissue); Right leg DTI 2 by 3 cm, evolving to open ulcer; Right ankle DTI 6 by 2 cm, evolving into open wound with loose blistered skin and Right foot DTI 4 by 2 cm. The ED nurse indicated, the foot/ankle/leg wounds were caused by the heel footdrop boots worn by Resident 1, per patient he was wearing them all the time. Removed them and recommended not using them again. The ED nurse also indicated that the patient's socks were, Unclean and stuck to the drainage on the bottom of his left foot and needed to be soaked off to prevent removal of skin. Review of the Physician's Order, with an order date of 11/08/16, it indicated, Heel boots at all times. During a review of the skilled facility's document, titled, Admission Summary, dated 11/5/2016, it indicated that Registered Nurse 3 (RN 3) noted an, Ulcer pressure wound, RN 3 did not identify the location(s) or size(s). RN 3 also noted, Changed the scrotal (testicles) wound dressing. During an interview on 12/15/16, at 12:50 p.m., RN 3 stated she made a mistake when she documented, Changed the scrotal (pouch of skin containing the testicles) wound dressing. RN 3 clarified that it was for a, Sacral (lower back) dressing change. RN 3 verified that Resident 1 only had a sacral wound. During a review of the facility's, Treatment Administration Record, (TAR) for the months of November 2016 and December 2016, there was no evidence of treatment of [REDACTED]. Review of the facility's tool, Weekly Pressure Ulcer BWAT dated 11/05/2016, 11/08/2016, 11/15/2016, 11/22/2016, and 11/29/2016, did not show evidence that the nurses had identified wounds on the left and right feet, ankles, heels, and legs. During an interview on 12/15/16, at 11:58 a.m., RN 2 stated he was familiar with Resident 1. RN 2 verified that Resident 1 only had a sacral wound. RN 2 stated that if skin breakdown was identified, an SBAR (Situation, Background, Assessment, and Recommendation-used to assist prompt and appropriate communication) would be initiated. During an interview on 12/15/16, at 2:25 p.m., RN 1 stated she worked with Resident 1 during the night shift, from 11 p.m. to 7 a.m. RN 1 verified that Resident 1 only had a sacral wound. RN 1 stated she was not aware of other skin breakdown or wounds on Resident 1. When asked if she performed a skin assessment for Resident 1, RN 1 stated the weekly skin assessments were completed by the P.M. (3 to 11 p.m.) shift nurses. During a telephone interview and concurrent record review on 3/27/17, at 7:36 a.m., the Director of Nursing Services (DNS), stated she reviewed Resident 1's electronic medical record and could not find evidence of documentation, except for the sacral wound, of any other new, current or on-going monitoring of skin breakdown while the resident was in the facility. The DNS stated that she should expect to find documentation by the nurses regarding skin breakdown or pressure ulcers in the Progress Notes, Weekly Pressure Report, and SBAR Tool. The DNS verified that there was no documentation regarding pressure ulcers on Resident 1's left and right legs, feet, ankles and heels. The DNS stated she looked through the paper chart (of the clinical record) and four shower sheets (completed by the Certified Nursing Assistants that identified skin breakdown on shower days), which showed no indication of skin breakdown or issues. The DNS verified that the chart showed no documentation in the chart to identify the pressure ulcers on Resident 1's left and right legs, feet, ankles and heels. During a telephone interview and concurrent record review, of the Comprehensive Assessment, dated November 7, 2016 that the Licensed Vocational Nurse (LVN) 1 noted, on 3/27/17, at 7:50 a.m., LVN 1 verified that Resident 1 only had a sacral wound. Review of Resident 1's Nursing Care Plan, with a revision date of 11/15/16, it indicated, Resident 1, Has a potential for pressure ulcer development r/t (related to) disease process, Hx (History) of ulcers, Immobility. The goal included, to Not develop any new areas of skin breakdown .staff will have interventions in place to prevent altered skin integrity . Interventions included: Follow policies and protocols for the prevention/treatment of [REDACTED].s/sx (signs and symptoms) of infection, wound size (length x (by) width x depth, stage. Review of the facility policy, titled, NCD (Nursing Care Division) Prevention and treatment of [REDACTED].a. Patients at risk for developing pressure ulcers are identified by using the Braden Scale (skin assessment tool) .c. pressure ulcer and other wound and skin related interventions are created in collaboration with the interdisciplinary team and implemented in order to identify, prevent or reduce the risk of acquiring pressure and/or non-pressure related wounds or skin issues .4. The Interdisciplinary team, patient/family collaborates to establish goals and interventions to address patient specific

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0314 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) risk factors for the prevention of skin alteration .5. The Interdisciplinary team and patient/family collaborates to establish goals and interventions to promote the healing of wounds and/or prevent further breakdown.