| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **056394** | A. BUILDING _____ B. WING _____ | **09/28/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **ST. FRANCIS CONVALESCENT PAVILION** | **99 ESCUELA DRIVE DALY CITY, CA 94015** |

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 0686<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Provide appropriate pressure ulcer care and prevent new ulcers from developing.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility failed to provide care to prevent pressure ulcer injuries (pressure induced skin and soft tissue injury) from developing to Resident 1, one of one sampled resident, who was at risk for skin breakdown when: 1. there was no evidence of skin assessment for signs and symptoms of skin breakdown from 2/7/18 to 2/20/18; 2. Pressure relieving mattress was not provided until 2/20/18, 13 days after admission; 3. Resident was not turned and repositioned, every two hours, according to care plan, from 2/7/18 to 2/20/18. The deficient practice resulted in the development of deep tissue (pressure) injuries to both heels of Resident 1 on 2/20/18. Definition of, Deep Tissue (Pressure) Injuries (DTI): Persistent non-blanchable (does not change color when touched) .purple, discoloration. Intact skin with localized area of persistent .purple discoloration due to damage to underlying soft tissue. This area may be .mushy .as compared to adjacent tissue .Results from .prolonged pressure .at the bone-muscle interface (connection) . Findings: Resident 1 was admitted for rehabilitation on 2/7/18 with [DIAGNOSES REDACTED]. The resident's Minimum Data Set (MDS), an assessment tool, dated 2/19/18, indicated moderately impaired cognition (thinking skills), required two staff assistants for transfer to chair/bed, and for repositioning in bed. Skin Conditions, Section M: Report based on highest stage of existing ulcer(s) at its worst . Risk of Pressure Ulcers: Is this resident at risk of developing pressure ulcers? Yes. Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher? No. Review of RN Admission sheet, undated, untimed, indicated, Using the diagram below .any findings of skin breakdown .Describe findings .Right and Left +3 [MEDICAL CONDITION] lower extremities . Definition of +3 [MEDICAL CONDITION] commonly refers to degree of pitting in the skin. Range 1+ - 4+, Mild - Severe. There was no indication pressure ulcers were present on the residents heels. Review of physician's orders [REDACTED].Elevate Bilateral (both) legs with pillows while in bed. Review of physician's orders [REDACTED].Monitor skin integrity every shift X 14 days then reassess. Review of physician's orders [REDACTED].Add foot rest to wheelchair, Elevate B/L (bilateral lower) legs when in chair and bed. Review of Resident Care Plan, dated 2/7/18, indicated, Problem: Risk for development of skin breakdown related to: Extensive Assist (required) in Bed Mobility. Goal: No skin breakdown .Approach: Examine skin during Activities of Daily Living (ADL's) for signs and symptoms of skin breakdown, Pressure Relieving Device (for) bed/wheelchair, Turn and Reposition every 2 hours . Activities of Daily Living are defined as the activities of the day, such as, getting up from bed, hygiene, dressing, eating, walking, etc. Review of ADL Sheet dated 2/7/18 through 2/20/20 showed no evidence of skin examination of residents heels every shift. Review of Resident Care Plan, dated 2/7/18, indicated, Problem: Self-Care Deficit related to: Goal: Resident's ADL needs will be met. Will not have further decline in ADL skills . Approach: Provide and/or assist resident with the ADL care every shift and as needed. Examine skin during ADL's & bathing for signs/symptoms (of) irritation or breakdown .Evaluate resident's ability in participating with ADL's and Rehabilitation .Mostly extensive assist in Activities of Daily Living (ADL's) care, Incontinent of Bladder .Physical Therapy and Occupational Therapy for Gait (walking) and Mobility Training . Review of Weekly Nursing Summary, dated 2/17/18, indicated, .Position every two hours .Skin Condition .Fair .[MEDICAL CONDITION]: + 3 Bilateral Lower Extremities . Review of Nurses Notes, dated 2/20/18, at 3 PM, indicated, .Resident noted with both heels, Deep Tissue Injury (DTI) this morning. Right heel 6 X 6 centimeter, unknown tissue damage .and Left heel 2 X 2 centimeter, unknown tissue damage .Skin still intact with both lower extremities, +3 ([MEDICAL CONDITION]). Resident complaining of pain, 4/10 (0 = no pain and 10 = most pain) during assessment .Low Air Loss Mattress ordered and delivered . Review of Nurse Practitioner Progress Note, dated 2/20/18, at 4:03 PM, .(Resident) is a [AGE] year old .transferred to Skilled Nursing Facility (SNF) for rehabilitation s/p (following) hospitalization for .lower extremities weakness . Nurse reporting bilateral (both) heel dark, fluid filled blisters . Physical Exam: .RLE (Right lower extremity) .Heel with large purple fluid filled blister, center is soft to touch. LLE (Left lower extremity) with purple fluid filled blister .Plan: Sure prep (medication) daily to blisters. Low air loss mattress. Float heels. Off loading shoe during rehabilitation . Review of Nurses Notes, dated 2/28/20, at 3 PM, indicated, .noted Right heel blister popped, treatment nurse notified already Review of Nurses Notes, dated 3/1/20, at 3 PM, indicated, Reassessment done to Right heel DTI with Nurse Practitioner, noted medial part (middle) popped about 2 centimeter-skin flap still in place .100% purplish in color . Review of Turning & Repositioning sheet, dated 2/21/18, indicated resident was not turned from 2/7/18 through 2/20/18, Turn and Reposition (Resident) every two hours while on bed, began 2/21/18, after deep tissue (pressure) injuries had formed on both heels. During an interview on 5/12/20, at 3:51 PM, the Director of Nurses (DON) stated, .They (staff) don't sign off, when questioned (if skin assessments were done every shift and low air loss mattress was applied to bed). I can't prove it's being done because it's not signed off. It could have helped to turn and reposition her every two hours. It could have been found sooner if they had. She stated turning & repositioning resident did not begin until 2/20/18, after the pressure injuries occurred. She did not know if resident's feet were floated (placed on pillows) starting 2/8/18, according to physician's orders [REDACTED]. that upon admission to the facility each patient shall have a total body check/skin assessment by a licensed nurse for the presence of pressure ulcers or proneness to their development .Procedure: .2. An assessment of care needs for pressure ulcer management will be made with emphasis on, but not limited to: a. Treatment b. Pressure-reducing devices .Documentation of findings will be entered in the nursing progress notes, care plan and Skin Integrity Sheet or Weekly Skin Condition Progress Report .Weekly response and assessment to treatment will be documented on the Skin Integrity Sheet or Weekly Skin Condition Progress Report and Nursing Weekly Summary. |

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.