STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555533	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Driftwood Healthcare Center - Hayward	19700 Hesperian Boulevard Hayward, CA 94541

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

Level of Harm - Actual harm

Residents Affected - Few

Provide appropriate pressure ulcer care and prevent new ulcers from developing.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46658

Based on interview and record review, the facility failed to provide pressure ulcer (a tissue injury resulting from unrelieved pressure over an area of the body) prevention and treatment for one of two sampled residents (Resident 1) when the facility failed to:

develop a care plan for Resident 1 ' s pressure ulcer upon discovery,

monitor Resident 1 ' s pressure ulcer,

provide a pressure reducing mattress,

and reposition Resident 1 off the pressure ulcer.

This failure resulted in Resident 1 developing a 1 cm (centimeter, a unit of measurement) x 1cm stage 2 (a classification of the severity of the pressure ulcer, stage 1 being a reddened area with intact skin, stage 2 indicating broken skin, stage 3 indicating an injury extending into tissue under the skin, and stage 4 indicating an injury extending into muscle and/or bone) pressure ulcer on the right buttock which grew to 7 cm x 7 cm over the course of 25 days and had become abscessed (a pocket of fluid resulting from infection).

Findings:

A review of Resident 1 ' s admission record indicated Resident 1 was admitted on [DATE] for pain management and rehabilitation after a left hip fracture. The admission record indicated Resident 1 was not self-responsible, and Resident Representative 1 (RRP) was Resident 1 ' s representative.

A record review of Resident 1 ' s nursing progress note, dated 3/31/23, indicated Resident 1 had an admission assessment performed by nursing staff. The progress note indicated Resident 1 did not have any open areas on the skin.

A record review of Resident 1 ' s observation report titled, Braden Scale (scale to assess risk for developing pressure ulcers) for predicting Pressure Sore Risk, dated 3/31/23, indicated Resident 1 had a Braden score of 12, indicating a high risk of developing pressure ulcers. The report indicated Resident 1 had very limited mobility and was not able to independently reposition oneself to prevent pressure ulcers. The reported indicated Resident 1 was Bedfast - confined to bed.

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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.

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

Printed: 08/01/2024
Form Approved OMB
No. 0938-0391

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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 0686 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 8/10/23, at 1:45 p.m., with the Director of Nursing (DON), Resident 1 ' s progress notes for April 2023 were reviewed. A progress note dated 4/2/2023, 5:49 p.m., indicated Licensed Nurse 2 (LN 2) identified an open area measuring 1cm x 1cm on the right buttock. The DON clarified the open area was a pressure ulcer. The DON stated LN 2 was the facility ' s wound care nurse. During a concurrent interview and record review, on 8/10/23, at 2:15p.m., with the DON, Resident 1 ' s minimum data set (MDS, an assessment tool to guide a resident ' s care), dated 4/5/23, was reviewed. The MDS indicated Resident 1 had a stage 2 pressure ulcer. The DON stated the stage 2 pressure ulcer was the right buttock wound identified on 4/2/23. The MDS indicated Resident 1 had a Brief Interview for Mental Status score of 13 (BIMS, a tool to assess a resident ' s status of memory and cognition, a score of 13-15 indicates intact cognition, 13-11 indicates moderate impairment.) A record review of Resident 1 ' s care plan for pressure ulcer, dated 5/2/23, indicated Resident 1 had four pressure ulcers including two on her left buttock and two on the right buttock. The care plan indicated Resident 1 had interventions for a pressure relief mattress, weekly wound assessments and skin checks and repositioning started on 5/5/23. Resident 1 did not have a pressure ulcer care plan in 4/2023. During a phone interview on 5/15/23, at 2:55 p.m., with RRP 1, RRP1 stated Resident 1 developed a pressure ulcer after she was admitted to the facility on [DATE]. RRP 1 stated she was admitted because of a hip fracture and had difficulty getting up. RRP1 stated Resident 1 did not have any wound on her buttock before admission. RRP 1 stated the facility needed a special mattress to prevent pressure ulcers, but the facility did not get one until over three weeks later. RRP 1 stated the facility did not monitor the wound and rarely repositioned her until it grew larger and became infected. During a record review of Resident 1 ' s Physician Orders Report, for dates 3/31/23 to 5/9/23, Resident 1 ' s physicians orders related to pressure ulcer treatments were reviewed. The report indicated Resident 1 had a physician order, dated 3/31/23, for a Weekly Nursing Summary which included skin monitoring. The report indicated Resident 1 had an order, dated 4/27/23, to monitor Pressure Ulcer site: right buttock. The report did not indicate an order for monitoring the pressure ulcer or right buttock wound site prior to 4/27/23. A review of Resident 1 ' s nursing progress notes, dated 4/1/23 to 4/27/23, indicated Resident 1 was on PUI (pressure ulcer injury) monitoring on dates, 4/3/23, 4/9-4/14, but the notes did not identify, describe, or measure a pressure injury. During a concurrent interview and record review, on 6/1/23, at 2:33 p.m., with Licensed Nurse 3, Resident 1 ' s weekly nursing summary, dated 4/17/23 and 4/24/23 were reviewed. The summaries indicated Resident 1 ' s skin was free of open areas for both dates. The 4/17/23 summary indicated turning/positioning was not monitored and lower extremities were not offloaded while in bed. LN 3 did not locate weekly nursing summaries prior to 4/17/23. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review, on 8/10/23, at 1:00 p.m., with the DON, Resident 1 ' s weekly nursing summary and wound management sheets for 4/2023 was reviewed. The DON stated weekly nursing summary reports were done on 4/17/23 and 4/24/23. The DON stated two wound management sheets dated 5/2/23 were completed by nursing staff. The DON stated there were no other weekly nursing summary or wound management sheets reports for 4/2023. The DON stated the wound care nurse and nursing staff would be expected to document the pressure ulcer status in a weekly nursing summary, in progress notes or on a wound management sheet. A record review of Resident 1 ' s nursing progress notes from 4/1/23 to 4/27/23, indicated Resident 1 was repositioned to a comfortable position on 4/3/23. A review of progress notes from 4/4/23 to 4/26/23 did not indicate Resident 1 was repositioned, and the notes did not indicate Resident 1 refused repositioning or wound care. During an interview on 6/1/23, at 11:06 a.m., with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated residents were typically turned and positioned if there was instruction by the nurse to do so. CNA 1 stated the CNAs did not document the times or the position of the turning and positioning but stated residents were turned and positioned every two hours. CNA 1 stated the nurse was responsible for documenting the turning and positioning. During an interview on 6/1/23, at 11:25 a.m., with Licensed Nurse 1 (LN 1), LN 1 stated nursing staff will instruct certified nursing assistants (CNA) to reposition residents who need to be turned. LN 1 stated the turning and positioning could be initiated without a physician ' s order. LN 1 stated CNA staff didn ' t document timing or position of turning and positioning. LN 1 stated nursing staff were responsible for documentation of turning and positioning. During a concurrent interview and record review on 6/1/23, at 11:25 a.m., with Licensed Nurse 3 (LN 3), Resident 1 ' s progress notes related to turning and repositioning for 4/2023 were reviewed. LN 3 stated if a resident was repositioned for wound management or prevention nursing staff would document the resident was repositioned. LN 3 stated she could not determine if Resident 1 was regularly repositioned off the pressure ulcer in 4/2023 after reviewing Resident 1 ' s progress notes. LN 3 stated she provided wound care nurse for Resident 1 but could not recall details of care provided. During a concurrent interview and record review on 8/10/23, at 12:50 p.m., with the DON, Resident 1 ' s physician order for a low air loss (LAL, an air mattress use to reduce pressure at areas for risk of pressure injury) mattress, dated 4/3/23, was reviewed. The DON stated if a resident needed a LAL mattress, the expectation was for the resident to be on a LAL mattress the same day if available. The order indicated nursing staff needed to document once a shift if the resident was on the LAL. A record review of a LAL mattress record titled, Special Bed/Mattress Report, dated 5/3/23, indicated Resident 1 had a LAL mattress initiated on 4/4/23, but did not indicate if Resident 1 was placed on a LAL mattress. During a concurrent interview and record review on 8/10/23, at 12:50 p.m., with the DON, Resident 1 ' s treatment administration record (TAR) for a LAL mattress for wound management and prevention, dated 4/3/2023, was reviewed. The TAR did not indicate Resident 1 was on a LAL mattress from 4/3/23 until 4/27/23. The DON stated the nursing staff were expected to document if Resident 1 was on a LAL mattress every shift according to the physician order. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1 ' s nursing progress notes, dated from 4/1/23 to 4/26/23, did not indicate Resident 1 was placed on a LAL mattress. A progress note, dated 4/27/23, by LN 2 indicated Resident 1 was on a LAL mattress. A record review of a LAL mattress record titled, Order Summary: Delivery 4501236869, dated 6/30/23, indicated a Dermafloat LAL mattress was rented for Resident 1 on 4/24/23 at 11:59 a.m. and was delivered on 4/24/23, at 6:10 p.m. The summary did not indicate if Resident 1 was placed on the Dermafloat mattress upon delivery. A record review of Resident 1 ' s nursing progress note, dated 4/27/23, at 2:43 p.m., by LN 2, indicated Resident 1 was ordered to start a five day course of antibiotics for a possible infection of the wound and received the first dose of Bactrim (a medication to treat bacterial infection) from the facility ' s e-kit (an emergency medication kit containing medications to treat immediate and/or serious medical issues) on 4/27/23. A record review of Resident 1 ' s nursing progress note, dated 4/27/23, at 2:06 p.m., by LN 2, indicated Resident 1 ' s open area on the right buttock was possibly infected. The progress note indicated the wound was red, tender and painful to touch. During a concurrent interview and record review, on 6/1/23, with LN 3, Resident 1 ' s Wound Management Detail Report, dated 5/2/23, by LN 2, was reviewed. The report indicated Resident 1 had a pressure ulcer on the right buttock which measured 7x7 cm and was not present on admission. The report indicated an incision and drainage (a surgical procedure to drain a wound of fluid) was performed on the wound. LN 3 stated this was the same wound identified on 4/2/23. During a phone interview on 10/5/23, at 11:00 a.m., with nurse practitioner 1 (NP 1), NP 1 stated she did not recall the condition of Resident 1 ' s right buttock pressure ulcer prior to the wound becoming infected on 4/27/23. NP 1 stated Resident 1 was at high risk of pressure ulcer development and worsening of existing wounds and expected nursing staff to closely monitor the resident for skin changes. During a phone interview on 10/5/23, at 11:45 a.m., with LN 2, LN 2 stated he did not regularly work at the facility and was on-call (working only when he was available). LN 2 stated nursing staff needed to monitor Resident 1 ' s wound weekly according to the physician order. LN 2 stated he did not recall the condition of the wound prior to his assessment on 4/27/23 but stated his documented assessment on 4/2/23 of an open area measuring 1cm x 1cm on the right buttock was accurate. LN 2 recalled the right buttock wound was obvious and could not be missed. A review of facility policy and procedure (P&P) titled, Pressure Ulcer and Skin Care Management, undated, indicated after a pressure ulcer is identified the facility develops the care plan using the clinical conditions and risk factors identified .considers and includes interventions for pressure ulcer .treatment to provide an aggressive program of consistent interventions by all staff involved. The P&P indicated a licensed nurse completes a pressure ulcer or skin report: when a pressure ulcer .is identified and weekly until healed.