WA # 120

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

PRINTED: 11/01/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	50G007		09/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND VILLAGE	S 2320 SALNAVE RD, PO BOX 200 MEDICAL LAKE, WA 99022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS	W 000		
	This report is the result of an Annual Recertification Survey and Complaint Investigations (2861225/2874630) conducted at Lakeland Village on 09/09/13 through 09/13/13. A sample of 12 residents was selected from a census of 128. The Expanded Sample included current residents.			
	The survey was conducted by: Janette Buchanan, R.N., B.S.N. Terry Patton, R.N., B.S.N. Claudia Baetge, M.A. Christina Borchardt, R.N., B.S.N.			
	The survey team is from: ICF/IID Survey and Certification Program Residential Care Services Division Aging and Long-Term Support Administration Department of Social and Health Services P O Box 45600 Olympia, Washington 98504-5600 Telephone: (360) 725-2405 Fax: (360) 725-2642			
W 104	483.410(a)(1) GOVERNING BODY	W 104		
	The governing body must exercise general policy, budget, and operating direction over the facility.			
	This STANDARD is not met as evidenced by:			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Anthony D. Barrera
TITLE: Superintendent
(X6) DATE: 11/04/13

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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W 104	Continued From page 1 Based on observations and interviews, the facility failed to ensure staff handled and stored food properly, ensured main kitchen staffs Food Handler cards were current and failed to ensure a hazard free environment. These failures placed residents at risk of harm for potential of food borne illness and at risk of potential tripping hazards and entrapment. Findings include: All observations, record reviews and interviews occurred between 9/9/13 and 9/13/13, unless otherwise specified. Refrigerators and freezers in Main kitchen 1. Half-gallon milk, open, not dated 2. Soy Blenders (1) quart, open, not dated 3. Krusteaz Golden Waffle box opened, not sealed ,exposed to air 4. 30 to 40 loaves of frozen bread dated 11/24/2012, 3/25/2013, and 4/26/2013. 5. Sweet pickle relish, 1 gallon, open, undated 6. Signature Deluxe Mayo, 1 gallon, open, undated 7. Miracle Whip, open, undated 8. Picture of unknown substance, unlabeled 9. Rejuv 100% Orange juice, open, undated 10. Hunts Ketchup, 20oz. ,open, undated 11. Rejuv 100% Apple Juice, open, undated 12. Kosher dill pickle chips, open, undated Interview with Staff W revealed facility policy was to use frozen food within 3 months. Interview with Staff E revealed facility policy was to use frozen food items within 6 months. Cabinets and wire carts in Main Kitchen 1. Pancake syrup, 1 gallon, open, undated 2. Molasses, 1 gallon, open, undated 3. Vanilla flavoring, open, undated 4. White Vinegar, 1 gallon, open, undated 5. Soy Sauce, 1 gallon, open, undated 6. Worcestershire Sauce, open, undated	W 104	W 104 The Food Services Manager conducted an in-service training of all kitchen staff in the proper Diet Manual 5.7 procedures of labeling food in containers; either individually or bulk (to include inner individually sealed) containers. This in-service training will stress the need for such stringent control procedures; with an emphasis of the potential health and potential foodborne illness risk. These labels will identify the date an item is opened and its expiration. Items removed from their original container and transferred to another container will also be labeled identifying the contents of the item. All secondary containers will be in good repair or replaced. The Food Services staff will ensure that all labels are maintained in a serviceable and legible manner. During the handling of containerized food staff will be	

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W 104	Continued From page 2 7. Cereal in plastic pitchers (Chex, Rice Krispies, Corn Flakes), not labeled, undated 8. Premium Salad Oil, 1 gallon, open, undated Food Handler Cards Record review revealed 3 staff (Staff L, K & R) Food Handler cards were not posted on kitchen bulletin board and not available during survey. Record review also revealed 3 staff (Staff R, X & Y) were currently out on L&I with return dates unknown. Facility was unable provide information when main kitchen staffs ' Food Handler card expired when they were not posted on kitchen bulletin board. Interview with Staff W revealed all kitchen staff were expected to renew their Food Handler cards and post on bulletin board located in kitchen break area prior to expiration. Staff W revealed main kitchen staff will remove their Food Handler card from the bulletin board and take with them when renewing their card. Staff W acknowledged when Food Handler cards were not posted on the bulletin board there could be a multitude of reasons yet all kitchen staff were required to post their Food Handler card. ATP - Room #10 Observation on 09/11/13 of ATP program (Room #10) revealed 2 of 12 sample residents (Resident #8 and 12) and 4 of 116 expanded sample residents (Resident # 18, 69, 91 and 123) were served a mixture of coffee and cocoa mixed with expired milk dated of 09/8/2013. Sunrise Cottage Observation on 09/09/13 at 10:55 AM revealed that 2 hallway doors giving egress to the rear emergency exit at Sunrise House were locked and residents could not exit through the rear fire exit in the event of a fire or other emergency. Interview with Staff EE revealed they keep the hallway door locked to prevent male residents	W 104	mindful to view that each container is properly marked with the required information and the label is in a serviceable/legible condition. If a label becomes damaged it will be immediately replaced and marked with the aforementioned required information. The Food Services Manager or Cook 3 on a weekly basis will perform random inspections of food containers to ensure the serviceability and proper identification of food containers. The Food Services Manager with the technical support of the IT Office has developed and implemented a Food Handlers Card database on September 20, 2013. This data base has been created to track the date that food handling has been completed and date of expiration. Thirty days prior to a staff member's expiration date the database will notify the Food Services Manager and Cook 3 of an approaching expiration date and	

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W 104	Continued From page 3 from going to the female side of the cottage and to keep female residents from going to the male side of the cottage. Interview with Staff N revealed that residents could not evacuate Sunrise Cottage via the rear emergency exit in the event of an emergency because the hallway doors were locked. Pinewood Cottage Observation at Pinewood Cottage on 09/09/13 at 9:45 AM revealed the gate in a fence outside an emergency exit at Pinewood Cottage was tied shut, preventing residents from leaving the area in the event of an emergency. Interview with Staff T revealed the gate is used as an emergency exit away from the house and it was probably tied shut on 09/06/13. Pathway to Douglas and Hillside cottages Observation on 09/11/13 revealed approximately 10 decorative bricks stacked in front of a white bench along the pathway to Douglas and Hillside cottages posed a trip hazard and did not allow the ability for residents to use the bench if they needed to sit and rest. Interview with Staff J revealed that the brick had been stacked there when there had been some type of work done on the garden area and had not been put back. Staff J immediately moved the bricks behind the bench so that they no longer posed a trip hazard.	W 104		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client.	W 120		

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W 120	Continued From page 4 This STANDARD is not met as evidenced by: Based on interview and record reviews, facility did not provide Physical Therapy (PT) services for 1 of 1 (Resident #3) sample residents between 06/16/13 and 07/03/13. This failure prevented Resident #3 from being evaluated for a proper mechanical lift sling, resulting in the resident being bed bound until seen by PT on 07/03/13. Findings include: All observations, record reviews and interviews occurred between 09/09/13 and 09/13/13, unless otherwise specified. Observation of Resident #3 on 09/10/13 revealed that due to [redacted] he is transferred by a mechanical lift using a full body sling. Record Review revealed Resident #3 ' s right femur was fractured on [redacted]/13 when Staff HH transferred Resident #3 from a recliner to a wheelchair using a 1-person stand and pivot transfer technique. Resident #3 returned to the facility from the hospital on [redacted] after having a metal rod placed to secure the fracture. Review of resident #3 records revealed on 06/15/13 Resident #3 was seen by Staff II, a part-time Physical Therapist, who noted Resident #3 needed to be a 2 person or mechanical lift transfer, with no weight bearing. On 06/17/13 Staff LL wrote that staff to follow PT directions. On 06/19/13, Staff A noted that staff were not able to safely move Resident #3 manually and they need to get a proper lift with a full sling. On 06/19/13 Staff LL noted that PT " is not available to work with Resident #3 and staff can set him on	W 120	W 120 Services Provided by Outside Services The facility will ensure services with contracted providers are completed promptly by revising the Lakeland Village EVENT/INCIDENT REPORT notification box to include notification of a Physical Therapist. A Physical Therapist will be notified by the immediate investigator of a client fracture before the end of the shift. The initiation of this notification by the end of the shift will ensure that Physical Therapy services are implemented following a timely assessment/evaluation of the client. The facility has corrected the deficiency as it relates to Client #3 by updating the Physical Therapy assessment and updating the IPP to reflect Client #3's current physical status.	

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W 120	Continued From page 5 the side of the bed to dangle but cannot get him out of bed. " Staff JJ evaluated Resident #3 on 07/03/13 at 9:45 AM recommended a full body sling be used with the mechanical lift to transfer Resident #3. Interview with Staff KK on 09/13/13 revealed that no physical therapist was available to consult with staff regarding Resident #3 between 06/17/13 and 07/3/13 because Staff JJ had been on vacation.	W 120		
W 137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observation and interviews, facility failed to ensure that 1 of 12 sampled residents (Resident #8) and 5 of 116 expanded sample residents (Resident #16, 45, 98, 99, and 112) had access to their tooth brushes and other toiletries. This failure prevented residents from independent grooming. Findings Include: All observations and interviews occurred between 9/9/13 and 9/13/13, unless otherwise specified. Observation of Big Foot cottage 94 side bathroom sink area revealed 2 locked clear plexi glass cabinets. One locked cabinet contained 6 toothbrushes and the other locked cabinet contained Dixie cups, mouthwash and a hairbrush. Interview with Staff F acknowledged cabinets	W 137		

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W 137	Continued From page 6 should not have been locked.	W 137		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record reviews, facility failed to report an incident regarding 1 of 1 resident (Resident #3) resulting in a fractured femur for 1 of 1 (Resident #3) sample residents to the Complaint Resolution Unit (CRU). This failure prevented CRU from ensuring timely, prompt and appropriate follow-up of the incident. Findings include: Record review revealed on 09/10/13 Resident #3 ' s right femur was fractured on 06/04/13 when Staff HH transferred Resident #3 from a recliner to a wheelchair using a 1-person stand and pivot transfer technique. Review of CRU Intakes for Lakeland Village revealed the facility did not report Resident #3 ' s femur was fractured when a staff transferred him on 06/04/13. Interview with Staff BB on 09/11/13 verified that the facility did not report the 06/04/13 incident during which caused Resident #3 sustained the fracture to the right femur.	W 153		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged	W 154		

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W 154	Continued From page 7 violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interviews and record reviews, facility failed to thoroughly investigate an incident pertaining to 1 of 1 (Resident #3) sample residents sustaining a fractured femur. This failure placed Resident #3 at risk of harm from potential future incidents due to unclear directions regarding transfers. Findings include: All observations, record reviews and interviews occurred between 09/09/13 and 09/13/13, unless otherwise specified. Record review of Resident #3 ' s records revealed that the right femur was fractured on 06/04/13 when Staff HH transferred Resident #3 from a recliner to a wheelchair using a 1-person stand and pivot transfer technique. The 1-person stand and pivot technique required Staff HH to stand in front of Resident #3 seated in the chair, support and help lift Resident #3 when he stands. Then Staff HH and Resident #3 both pivoted toward the wheelchair and Staff HH helped lower the resident into the wheelchair. Review of the facility investigation dated 06/05/13 revealed the conclusion that Staff HH appropriately supported Resident #3 during the 06/04/13 transfer which resulted in Resident #3 ' s fractured femur. During a telephone interview on 09/13/13 Staff HH revealed that when he attempted to pivot Resident #3 toward the wheelchair, Resident #3 ' s body moved around but his right foot did not and Staff HH heard a loud " pop " sound. Staff	W 154	W 154 STAFF TREATMENT OF CLIENTS The facility will have evidence that all event/incidents are thoroughly investigated. The facility failed to follow outlined procedures regarding facility investigations. The LV Event/Incident report will contain all the documentary/ demonstrative and other relevant evidence. The immediate investigation is reviewed by the Administrative reviewer. The Administrative reviewer will ensure that all relevant evidence is preserved and provided to the CIM investigators. The CIM investigator will review the facility LV Event/Incident report to ensure the Central Office and CRU reports and relevant evidence is provided and the packet is complete. The HPA will update client #3 current IPP and the Physical Therapy assessment and provide clear direction regarding transfers. These documents have been updated to	

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W 154	Continued From page 8 HH stated he always did a one person stand and pivot when transferring Resident #3 from a chair to the wheelchair because that is what they were taught. The facility investigation did not reveal Staff HH failed to ensure Resident #3 ' s foot was free to turn during the transfer. Facility investigation also failed to identify these inconsistencies in the transfer requirements for Resident #3: 1. 11/12/09 Staff JJ recommended " ...a mechanical lift should be used if staff are not able to safely assist with stand-pivot transfers. " This documentation does not identify how staff are to know, prior to a problem occurring, if they are able to safely assist with transfers. 2. 10/03/12 Profile AP-PM (Room 5) for Resident #3 noted that Resident #3 needed a mechanical lift as adaptive equipment. 3. 04/19/13 Medical History and Physical for Resident #3 noted he was " able to stand, pivot transfer with the assist of 2 ... " 4. Physician Orders signed by Staff C dated 05/22/13 noted " Due to mobility limitations, use a mechanical lift PRN. " The documentation did not reveal when a mechanical lift should be used PRN. 5. Quarterly Nursing Health Care Review by Staff MM dated 05/17/13 noted, " Due to mobility limitations, use a mechanical lift PRN. " Documentation did not reveal when a mechanical lift should be used PRN. 6. Individual Habilitation Plan (IHP) dated 05/07/13 for Resident #3 noted, " Due to mobility limitations, use a mechanical lift PRN. " However, it also noted Resident #3, " Stands and assists in transfers ... " Documentation did not reveal when a mechanical lift should be used PRN or be used when Resident #3 can stand.	W 154	accurately reflect the client's current status. Completed for client #3 as verified on November 1, 2013. All staff will be in-serviced on LV 10.6.b, Client Protection: Immediate Investigations, LV 10.6 d Client Protection: Administrative Reviews. If the CIM investigator believes that additional information or other relevant documentation should be obtained they can access additional information electronically or in the Client Unit Record. The DDA 1 or designee will review the packet following the Administrative Review. The HPA's will conduct a Significant Change of Status meeting and provide documentation of significant events when a fracture changes the client's functional status. Update of assessments will occur so as to accurately reflect the client's current status and provide clear directions regarding client mobility.	

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W 154	Continued From page 9 Interview with Staff B revealed he approved the 5-Day Investigation Report on 07/13/13.	W 154		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on interviews and record review, facility failed to provide proper training for two staff members (Staff P & Q) who had recently begun working at Bigfoot Cottage regarding 1 of 116 expanded residents ' (Resident #16) therapeutic diet. As a result Resident #16 was served the wrong diet. Findings include: Record review revealed on 09/09/13 Resident #16 at approximately 5:20 pm resident was given the wrong diet texture. Resident immediately began coughing. Nursing was notified immediately and assessed residents lung sounds for any signs or symptoms of aspiration. When the facility investigated the incident it was noted that neither Staff P nor Staff Q were aware of the diet that Resident #16 was to have, due to not being oriented to the residents on the cottage as is the policy of the facility.	W 189		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active	W 249		

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W 249	Continued From page 10 treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, facility failed to provide a continuous active treatment program consistent with current IHP (Individual Habilitation Plan) for 1 of 12 (Resident #3) sample residents. This failure prevented the resident from having an opportunity to learn skill development and work toward accomplishing their objectives. Findings include: All observations, record reviews and interviews occurred between 09/9/13 and 09/13/13, unless otherwise specified. Resident #3 was observed on 09/11/13 from 2:20 PM to 2:45 PM. He was observed sitting in his wheelchair throughout this time. He did not participate in any activities during this time and occasionally appeared to be falling asleep. Interview with Staff NN revealed that during the afternoon class Resident #3 performs his program, pressing down on a jig, for about an hour before their break. A different resident performs this task after the break. When the other resident is using the jig, Resident #3 was not engaged in his program. Staff NN also explained that sometimes they do not have the parts to put into the jig and Resident #3 's	W 249	W 249 The facility will ensure that each client is provided a continuous Active Treatment program by offering activities/programs as stated in the IHP. The AP program that client #3 was on is being deleted. His AP program will not be centered on a task that involves production materials that may not always be available. His program will reflect more of what his assessed need is. The X on the Program Recording form indicates program not run with documented reason on back of the form. When the client has finished his formal objective and is willing to stay at the work site, AP staff will provide opportunities and let him choose alternate activities. If the client is tired, AP staff will exhaust all options to keep the client awake and engaged before sending the client home. AP Room 5 Program Managers will be in-serviced on accurate and	

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W 249	Continued From page 11 training program cannot be run. Staff NN stated that an X in the AP Monthly Reporting Program Recording Form shows the training program was not run that day and the reason it wasn ' t run should be explained on the back of the form. Review of Resident #3 ' s AP Monthly Program Recording Form reveals: 1. Resident #3 ' s training program was not done for 87 days from 04/08/13 through 09/12/13. 2. No reason is given on the back of the AP Monthly Program Recording Form explaining why the program was not run on 29 days between 04/08/13 and 09/12/13. 3. Comment on back of form by Staff NN notes Resident #3 ' s program was not run between 04/22/13 to 05/16/13 because there were no parts available to assemble. However, scoring on the front of the Recording Form shows the program was run from 05/13/13 through 05/16/13.	W 249		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, record review and interviews, facility failed to obtain abridgement consents prior to implementation of restrictive programs that removed shower handles from shower rooms for 16 expanded sample residents (Residents ' # 19, 22, 37, 39, 40, 41, 42, 44, 53,	W 263		

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W 263	Continued From page 12 58, 67, 77, 84, 87, 93, & 99). This failure denied the residents/guardians the opportunity to make informed decisions about facility restrictive practices and denied residents their right to shower independently at their residence. Findings include: All observations, record reviews and interviews occurred between 09/09/13 and 09/13/13, unless otherwise specified. Observation of shower rooms at Apple 92/93 side, Bigfoot 92/93 side and Hillside 65 side revealed shower handles were removed from the shower areas. Record review of resident roster listed 22 residents who could shower independently without staff assistance. Interview with Staff U revealed shower keys were locked up to prevent the residents from turning on the water and staff were always present at shower times to ensure resident safety. Staff U provided surveyor with Lakeland Village directive dated 09/06/06 for bathing expectations for all Lakeland Village residents which stated bath keys (handles to the baths and showers) will be secured outside the bathing area. These may be stored in a secure manner or locked for resident safety. Interview with Staff B acknowledged this has been a facility practice following three incidents involving residents ' drowning. The only exception in having shower handles is on the 88 side of Wildrose. Facility was unable to produce abridgement consents for 16 residents who were independent and have the ability to shower without asking staff for shower keys or requiring	W 263	W 263 The Audit Team selected Level of Support 3 to indicate independent showering. LS3 in and of itself is not an accurate measure of showering skills/abilities. Of the 16 sited clients, the facility will ensure abridgements are completed on those who can shower independently. The facility will also continue to have staff follow the directive dated 9/6/2006 for bathing expectations that will be republished to all cottage staff with the same expectation which states bath keys (handles to the baths and showers) will be secured outside the bathing area. These may be stored in a secure manner or locked for client safety. Guardians will be provided the opportunity to review LV abridgement and restrictive procedure and provide input if any. The facility will look at all assessments to determine which	

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W 263	Continued From page 13 supervision while showering.	W 263		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on interviews and record reviews, facility failed to provide 1 of 1 (Resident #52) expanded sample residents with pulse and blood pressure checks weekly as directed by nursing orders. This failure placed Resident #52 at risk of harm from potential medical complications. Findings include: Observation at 8:00 AM on 09/10/13 revealed Resident #52 was given Enalapril 20 mg as ordered. Resident #52 has received the Enalapril since 06/12. Review of Resident #52 ' s records on 09/11/13 revealed a nursing order requiring Resident #52 ' s pulse and blood pressure should be taken once a week before hypertension medication is given and also as necessary. Review of the nursing orders from March 1, 2013, through September 11, 2013, reveal blood pressures and pulses were not taken: March 23 through April 4th, April 6th through April 18th, April 20th through May 23rd, June 1st through June 20th, June 29th through July 18th, July 20th through August 1st, August 3rd through August 16th, and August 24th through September 11th. Interview with Staff MM on 09/11/13 revealed that she was the team leader for Resident #52 and was not aware Blood pressure and Pulses were not being completed weekly.	W 322		

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W 323	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. This STANDARD is not met as evidenced by: Based on record reviews and interviews, facility failed to perform a recommended vision exam for 1 of 12 sampled residents (Resident #11). Failure to provide a vision exam placed resident at risk of unidentified changes in vision or other medical issues which could lead to deterioration in their overall health. Findings include: All interviews and record reviews were conducted between 09/09/13 and 09/13/13, unless otherwise specified. Record review revealed a 06/02/2009 Eye Examination report for Resident #11. The Eye Consultant recommended Resident #11 follow-up in three years. No further Eye Examination Reports were found in Resident #11 ' s records. Interview with Staff BB revealed Resident #11 ' s 06/02/2009 Eye Exam report was the most current on record.	W 323		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review, facility failed to ensure that 1 of 116 expanded sample residents (Resident #15) received the correct nursing interventions. This failure prevented Resident #15 from receiving the correct medication when admitted to the facility and having the potential for	W 331		

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W 331	Continued From page 15 harm. Findings include: Record reviews occurred between 09/09/13 and 09/13/13, unless otherwise specified. Resident #15 came with an order for [redacted] liquid 0.5mg twice a day. On 05/21/13, 05/22/13, and 05/23/13, Resident #15 received [redacted] liquid 5 mg twice a day instead of the prescribed 0.5 mg twice a day. Review of facility ' s 5-Day Investigation Report on 09/10/13 revealed that on 05/20/13 Resident #15 was admitted to the facility as a respite client. When Resident #15 was admitted Staff X received a copy of Resident #15 ' s discharge orders from the Group Home that Resident #15 had previously lived at. Staff X copied the Group Home ' s medication reconciliation record (MAR) which included the medication [redacted] liquid. Staff X informed the Health Care Provider (Staff C) that Resident #15 had one medication and that the dosage was 0.5mg.Staff X was asked to read the concentration from the label on the box of the medication that had arrived with the resident to Staff C. When Staff X gave the order to Staff C the order was transcribed incorrectly causing Resident #15 to get 5 mg of [redacted] twice a day instead of 0.5mg twice a day which was the actual order. This error continued for 3 days before a consultant found the error and brought it to the facility attention. Review of the facility ' s Nursing Procedure 9.5 pertaining to medication orders reveals: 1. Nursing staff are permitted to act on	W 331	W 331-Nursing Services The facility will provide clients with nursing services according to their needs. The facility failed to ensure that Client #15 received the correct nursing interventions. Resident will receive the correct nursing interventions including preventative and general medical care in the event he returns for respite care. The facility referred this medication error to the CIMS for a thorough investigation. Nursing staff that were involved in this medication error were in-serviced on Nursing Procedure 9.5 regarding appropriate and accurate doctor order transcription and verification. This in-service was completed on 7/2/13. All Nursing staff had been directed to review current nursing procedure 9.5 in order to prevent future medication errors and to ensure understanding of the procedure. Staff X was given individualized in-servicing on this	

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W 331	Continued From page 16 verbal/telephone orders provided the orders contain appropriate information and are within their scope of practice. 2. Verbal orders will be accepted ONLY in emergency/life threatening situations (i.e., medical STATS, hemorrhage, cardiac arrhythmia, shock, and coma.) 3. Telephone orders can ONLY be accepted and written by the RN/LPH and ONLY when the physician is off campus or involved in acute care (providing direct care to a client) or in a client emergency. 4. The nurse accepting the order must be the same nurse writing the order. 5. The RN/LPN will read back the order, in its entirety, to the physician at the time the order is given for verification prior to terminating the telephone call and write " Verified " after the notation " Telephone Order ". 6. All physician orders will undergo a " Double or Validation Check Process " within 24 hours of the original date and time the order was written. Example: if the order starts the process during shift one, it must complete the validation check no later than shift three. The facility did not follow their process which led to Resident #15 receiving the incorrect dosage of Risperidone for 3 days.	W 331		
W 332	483.460(c)(1) NURSING SERVICES Nursing services must include participation as appropriate in the development, review, and update of an individual program plan as part of the interdisciplinary team process. This STANDARD is not met as evidenced by:	W 332		

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W 332	Continued From page 17 Based on record review and interviews, facility failed to review and update the End of Life/Palliative Care Plan Consent for 1 of 1 sample residents (Resident #11). This failure placed resident at risk of not receiving medical treatment in accordance with any health care changes. Findings include: All record reviews and interviews were conducted between 09/09/13 to 09/13/13 unless otherwise indicated. Record review of End of Life/Palliative Care Plan (Revised date 04/13/2011) for Resident #11 revealed resident has [redacted] Record Review of End of Life/Palliative Care Plan Informed Consent was signed by Staff OO, Staff X and Staff PP on 03/15/2012. Staff QQ and Staff RR signatures were noted on file for 09/09/2010 and Staff SS signature was noted on file for 09/10/2010. Record review of End of Life/Palliative Care Informed Consent for Resident #11 revealed the forms will be reviewed and updated when the plan changes or at the annual IHP meeting. Interview with Staff BB revealed that the current End of Life/Palliative Care Plan for Resident #11 was in the file and the informed consent had not been updated since 03/15/2012.	W 332		
W 334	483.460(c)(3)(i) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be by a direct physical examination.	W 334		

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W 334	Continued From page 18 This STANDARD is not met as evidenced by: Based on interviews and record reviews, facility failed to complete quarterly nursing physical assessments for 12 of 12 sample residents (Resident #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, & 12). This failure placed residents at risk for decline of health and well-being due to unidentified health issues from lack of/or incomplete review and/or examination of body systems. Findings include: All interviews and record reviews were conducted between 09/09/13 and 09/13/13 unless otherwise stated. Record reviews revealed: · Resident #2 had no documented Quarterly Nursing Health Care Reviews (direct examination of the resident) within the past year; however the named Resident had quarterly nursing chart reviews in place. · Resident #3 had Quarterly Nursing Health Care Reviews dated 2/21/13, 5/21/13, and 8/1/13. None of these quarterly reviews revealed a direct examination of the resident had been completed. · Resident #4 had a Quarterly Nursing Care Review dated 07/31/2013, Annual Nursing Review and Recommendations dated 07/10/2013. None of these reviews revealed a direct examination of the resident had been completed quarterly. · Resident #5 did have the IMR Quarterly Nursing Health Care Reviews for the chart reviews completed. Resident #5 had an IMR Quarterly Physical Assessment (one of the facility forms for the direct examination of the resident)	W 334	W 334 NURSING SERVICES The facility will have evidence that Nursing Services have completed quarterly nursing physical assessments. A direct physical examination will include a visual review of the body as well as examination/observation of body systems. The physical exam will be completed as evidenced by the completion of the updated "NURSING HEAD-TO-TOE PHYSICAL ASSESSMENT" for the following clients; 1,2,3,4,5,6,7,8,9,10,11,& 12. The Clients listed in the deficiency will have nursing head-to-toe physical assessments completed. The nursing staff will identify clients who have not had a quarterly physical assessment in the last 6 months. The identified clients will receive a "NURSING HEAD-TO-TOE PHYSICAL ASSESSMENT" by November 13, 2013. This documentation will ensure that the clients are not at risk of decline of health and well-being due to	

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W 334	Continued From page 19 that was dated 08/14/13. Three direct examinations of the resident were not completed. · Resident #6 had no documented Quarterly Nursing Care Reviews. On 9/12/13 staff were able to locate one Quarterly Nursing Direct Physical Examination, dated 1/16/13. · Resident #7 had Resident had Quarterly Nursing Chart Reviews completed for the year. None of these quarterly reviews revealed a direct examination of the resident had been completed. · Resident #8 had Quarterly Nursing Care Reviews dated 06/12/2013 and 09/4/2013. An Annual Nursing Review and Recommendations dated 07/06/2013. One direct examination of the resident was completed on 06/18/2013. · Resident #10 had an ICF-ID Quarterly Physical Assessment completed on 07/19/13. No direct examination of the resident had been completed quarterly. None of these quarterly reviews revealed a direct examination of the resident had been completed. · Resident #11 had completed Quarterly Nursing Health Care Reviews for July 2013, April 2013, January 2013 and an Annual Nursing Review dated 02/28/2013. . None of these quarterly reviews revealed a direct examination of the resident had been completed. · Resident #12 had one Quarterly Nursing Direct Physical Examinations, dated 7/30/13. Three direct examinations of the resident were not completed. Interview of Staff A revealed that the facility ' s policy titled " Quarterly Nursing Health Care Review, " documented a Registered Nurse or designee will use the quarterly physical assessment and MOSES (a tool used for monitoring of side effects) form and be	W 334	unidentified health issues from lack of or in-complete review and/or examination of body systems. All nurses will receive an in-service on Nursing Procedure 1.6 ICF-ID Quarterly Nursing Health Care Review which will be revised to ensure the definition of head-to-toe assessment includes that all documentation will ensure that the clients are not at risk of decline of health and well-being due to unidentified health issues from lack of/or in-complete review and/or examination of body systems. The RN3 or designee will perform audits on 5 clients per quarter to ensure current procedures regarding quarterly physicals are followed. Completion Date: November 13, 2013 and ongoing. Responsible: PAT Director/RN4/DDA1.	

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W 334	Continued From page 20 responsible for completing three of the four required direct physical)assessments per year.	W 334		
W 367	483.460(k) DRUG ADMINISTRATION The facility must have an organized system for drug administration that identifies each drug up to the point of administration. This STANDARD is not met as evidenced by: Based on observation, record review and interviews , facility failed to provide for accurate drug administration and identification up to the point of administration for 1 of 12 sample residents (Resident #8) and 1 of 116 expanded sample residents (Resident #16). This failure placed residents at risk for potential harm from receiving the wrong medication. Findings include: Observation of medication administration on 9/10/2013 at 8:00am revealed Staff DD preparing medication for administration for Resident #16. Staff DD was observed punching the medication from the bubble packs for Resident #16 into a Dixie cup. Staff DD then prepared medication for another resident (Resident #8). Staff DD left the medication room to give Resident #8 his medication leaving medication for Resident #16 sitting on the counter in the medication room. Record review of the facility ' s General Principles of Medication Administration Policy (Revised 04/25/2010) revealed the RN/LPN (Registered Nurse/Licensed Practical Nurse) are assigned the responsibility for preparation, administration and documentation of the medications and the security of the drug storage area. The RN/LPN will prepare and set up medications for one	W 367		

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W 367	Continued From page 21 resident at a time followed by immediate administration of the medication. Interview with Staff DD regarding AM medication administration for Resident #16 on 09/10/2013 revealed Staff DD had gotten distracted and left Resident #16 ' s medication on counter. Staff DD acknowledged that she should have given to Resident #16 the medication before leaving the area and not have leaving them in a medication cup on the counter.	W 367		
W 425	483.470(d)(2) CLIENT BATHROOMS The facility must provide for individual privacy in toilets, bathtubs, and showers. This STANDARD is not met as evidenced by: Based on observation, record review and interview, facility failed to ensure 2 of 12 sample residents (Resident #5 & 10) and 12 of 116 expanded sample residents (Resident #20, 26, 28, 29, 47, 82, 83, 88, 90, 97, 101, 106) had privacy while bathing. This failure to provide privacy violated the 14 residents ' right to privacy. Findings include: Observation 09/13/13 of Hillside Cottage (64 side) hydro tub area revealed a section of the privacy curtain missing and would not provide a resident privacy while bathing. From the hallway entrance the hydro tub was visible. Record review revealed that the last work order to replace the privacy curtain was on 01/22/13. Interview with Staff CC acknowledged a missing	W 425		

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W 425	Continued From page 22 portion of the privacy curtain for the hydro tub area. He stated there is a resident that likes to tear down the curtains and a work order had been submitted. Staff CC revealed someone most likely just forgot to record in record book. Staff CC indicated a plan to resubmit a work order to replace the missing privacy curtain.	W 425		
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observations and interviews, facility failed to ensure infection control practices were observed in 2 of 2 kitchens (Main and Pinewood Cottage). Food preparations in the main kitchen and Pinewood Cottage were completed in a manner which could cause cross-contamination. These failures placed residents at risk of illness due to improper usage of gloves. Findings include: All observations and interviews occurred between 9/9/13 and 9/13/13, unless otherwise specified. Observation of food preparation in main kitchen area on 9/9/2013 revealed: 1. A staff wearing gloves while kneading meat. Staff later removed her gloves, washed her hands, picked up a new pair of gloves and placed the gloves on a soiled counter before putting new gloves on. 2. A staff wearing gloves chopping lettuce in a container and pushing the lettuce down with her hands. Staff then opened the kitchen drawer to obtain an item and continued chopping lettuce	W 455		

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W 455	Continued From page 23 and pushing down the lettuce with the same pair of gloves. 3. A staff labeling Styrofoam food containers proceeded to use scooping utensils which had been laying on dirty dish towels to scoop fruit cocktail into Styrofoam containers. 4. A staff kneaded meat while wearing gloves then picked up a 1 gallon jug of sauce and poured the sauce into the meat. Staff hand kneaded the meat using the same gloves. Interview with Staff E revealed staff are expected to wear gloves during food preparation and are expected to change gloves if other items are touched. Observation of food service during lunch at Pinewood Cottage on 9/11/13 revealed: 1. Staff FF spread margarine on 6 slices of white bread while wearing gloves. He touched the bread, the container of margarine, the knife he used to spread the margarine, the plate he put the bread on, as well as touching the counter and the refrigerator door, all while wearing the same gloves. Staff FF had handled several beverage containers using his bare hands. Then Staff FF removed a straw from a wrapper without gloving or sanitizing his hands and placed the straw in Resident #3 ' s beverage, while holding the end of the straw that Resident #3 put in his mouth. 2. Staff GG touched bowls, removed lids, touched the table, and removed the wrapper from slices of cheese. He then broke up the cheese and put it on Resident #14 ' s food, all while wearing the same pair of gloves.	W 455		
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and	W 460		

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	50G007		09/13/2013

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W 460	Continued From page 24 specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, and record reviews, facility failed to ensure 1 of 116 expanded sample residents (Resident #29) received the proper liquid thickening agent consistency and 2 of 116 expanded sample residents (Resident #16 & 17) received the correct diets. This failure prevented Resident #29 from receiving the correct amount of thickening agent for her fluids which could have led to aspiration of the fluids and Resident #16 & 17 from receiving the correct diets which placed them at risk of harm for aspiration. Findings include: All observations and record reviews occurred between 09/09/13 and 09/13/13, unless otherwise specified. Observation of lunch on 09/10/13 at approximately 11:05 am revealed that at Hillside Cottage, Staff noted the consistency of Resident #29 ' s meat gravy was too thin (pudding thick). The staff member took the container (Styrofoam 1 quart) to the cottage kitchen and got the thickening agent out of the cupboard and began pouring a couple of spoonful ' s of the thickening agent into the container and began mixing it. The staff person then served the thickened gravy to the resident. The staff person did not follow the directions on the side of the container; therefore there was no assurance that the gravy he prepared for Resident #29 had the proper consistency for resident. Record review of facility incident report for	W 460	W460-Food and Nutrition Wrong Liquid Thickening Agent Consistency. The facility will ensure that each client is receiving a nourishing, well balance diet including modified and specialty-prescribed diets. The facility will ensure that Client #29 receives the proper liquid thickening agent consistency. The Speech Pathologist will in-service the Hillside care staff directly regarding adding THICKENER to food products and mixing to the desired consistency (spoon/pudding thick). Upon training completion, Client #29's care staff will sign a "Staff Development Attendance Record Specialized Training" form. Wrong Therapeutic Diet. Resident #16 received the wrong therapeutic diet which came prepared from the kitchen. Resident #16 ate the wrong therapeutic diet before the staff could intervene. This incident was	

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W 460	Continued From page 25 08/14/13 revealed Resident #16 received the wrong therapeutic meal. Resident #16 is a respite resident (admitted 08/13/13) at the facility and was admitted on a Gluten Free diet (A gluten-free diet is a diet <http://en.wikipedia.org/wiki/Diet_(nutrition)> that excludes foods containing gluten <http://en.wikipedia.org/wiki/Gluten>. Gluten is a protein complex found in wheat <http://en.wikipedia.org/wiki/Wheat> , barley <http://en.wikipedia.org/wiki/Barley>, and rye <http://en.wikipedia.org/wiki/Rye>. A gluten-free diet is the only medically accepted treatment for celiac disease <http://en.wikipedia.org/wiki/Coeliac_disease>). Resident #16 ' s dinner was prepared by the kitchen staff and came in a dinner tray. When it was time to eat, staff became distracted by another resident having behaviors, and Resident #16 ate the food before staff could intervene. When staff became aware of the error they contacted nursing staff and had resident evaluated right away. Resident did not have any residual problems from eating the wrong diet. The facility investigation notes that the Staff L did not follow the proper procedure to ensure that the resident received the proper diet. Record review of facility incident report for 09/09/13 revealed Resident #17 received the wrong textured diet when Staff P handed Staff Q a bowl of soup to give to the resident. Resident #17 is to receive a dysphagia mechanically altered diet with slurry bread products and honey or spoon/pudding consistency liquids. Resident #17 received soup that consisted of kidney beans, potatoes and noodles that were overcooked. Resident began to cough and staff immediately removed the soup from in front of	W 460	thoroughly investigated by the CIMS. All Kitchen staff were in-serviced regarding "gluten free diets". This in-service was completed on 9/4/13. Wrong Textured Diet. The facility will ensure that each client is receiving a nourishing, well balance diet including modified and specialty-prescribed diets The facility will ensure that Client #17 receives the proper textured diet and liquid consistency. The Speech Pathologist will in-service Client#17's care staff (Bigfoot) directly regarding the visual identification of his specific food texture. Upon training completion, Client #17's care staff will sign a "Staff Development Attendance Record Specialized Training" form. Also, the "Cottage Orientation Sheet" includes the diet textures and liquid consistencies for all the clients. When new or floating staff are assigned to the cottage, a regular staff member will review	

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W 460	Continued From page 26 resident and notified the nurse. Per the facility investigation the facility had not ensured that the staff working on the cottage (Staff P and Q) was properly trained to the unit.	W 460		
W 473	483.480(b)(2)(ii) MEAL SERVICES Food must be served at appropriate temperature. This STANDARD is not met as evidenced by: Based on observation and interviews, facility failed to serve food at the appropriate food temperature for hot and cold items at Bigfoot and Pinewood cottages. Failure to serve food at the appropriate temperatures resulted in residents being served food at inappropriate temperatures creating potential for foodborne illness. Findings include: All observations and interviews occurred 09/11/13, unless otherwise specified. Bigfoot Observation at 11:30 AM revealed a special diabetic meal containing a ground unknown substance and gravy was served at 120° (temperature to be 140 degrees or higher when served) to 1 of 116 expanded sample residents (Resident #121). Pinewood Observation of cold food temperatures at 11:25 AM revealed the cold foods arrived from the main facility kitchen above the maximum safe temperature of 45 degrees. Mixed fruit was 51.6 degrees and pureed fruit was at 48.5 degrees. Interview with Staff B revealed the cottage is the last stop for meal delivery and that the cold foods are not kept in insulated containers during	W 473		

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W 473	Continued From page 27 delivery.	W 473		
W 478	483.480(c)(1)(ii) MENUS Menus must provide a variety of foods at each meal. This STANDARD is not met as evidenced by: Based observations, interviews, and record reviews, facility failed to ensure meal choices were offered to 1 of 12 sample residents (Resident #10) and 3 of 116 expanded sample residents (Resident #29, 88, & 90) that received specialized diets. This failure does not provide the resident with meal choices when on a specialized diet. Findings include: Observation on 09/10/13 at Hillside Cottage at approximately 11:20 am revealed Resident #10 was given a metal tin that contained her specialized diet (ground meat/rice milk). Resident #10 ate the meal without being asked if she would rather have something else to eat that would fit into her diet plan. Observation lunch time on 09/10/13 revealed Staff did not offer meal choices to Resident #29, 88 or 90 on Hillside Cottage. Resident #29 was given a puree diet that was served up by the staff from the metal tin that had been prepared in the main kitchen and at no time was she offered an alternative to what she had been served. Resident #88 was served a mechanical soft diet that had come from the main kitchen. Resident #88 was assisted in scooping the food onto her plate and no time was she offered an alternative	W 478		

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W 478	Continued From page 28 meal choice. Resident #90 had a regular diet that came in a metal tin already prepared from the kitchen that he was able to scoop out onto a plate with some cueing from the staff. Resident #90 was independent in getting his meal tray from the kitchen counter, opening it and placing the food on his plate. Staff did not asked if he would like something different to eat instead of what he received from the main kitchen. Record review on 09/10/13 revealed that Resident #10 was on a specialized diet (ground meats with no added salt and no dairy) for all meals secondary to choking issues. Review of facility diet sheet that was provided facility management on 09/09/13 verified the diets for Resident #10 and 29 ' s specialized diets. Interview with Staff J on 09/10/13 after the lunch meal revealed that all the residents on the specialized diets are to be offered an alternative. Staff J stated she did not know why staff had not offered an alternative to the residents as it is an expectation.	W 478	W 478 The facility will ensure clients have choices at meal times even those on a special diet, by providing appropriate alternative choices. Staff will ask clients if they want what is in their special diet tray or an alternative that still meets the requirements of their special diet. An all staff memo will be sent out with reminders to staff to provide choices at meal times. ACMs will do meal time audits of all 3 meals on a monthly basis to ensure choices are being offered. Completion Date: November 13, 2013 and ongoing. Responsible: PAT Director/DDA1/ACM.	