

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/18/2013
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NAME OF PROVIDER OR SUPPLIER BETHANY AT SILVER LAKE	STREET ADDRESS, CITY, STATE, ZIP CODE 2235 LAKE HEIGHTS DRIVE EVERETT, WA 98208
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Bethany at Silver Lake 04/10/13, 04/11/13, 04/12/13, 04/15/13, 04/16/13, 04/17/13 and 04/18/13. A sample of 38 residents was selected from a census of 102. The sample included 23 current records and the records of 15 former and/or discharged residents.</p> <p>AMENDED PER IDR ON 7/3/13 BY MIKE TORNQUIST</p> <p>Survey team members included:</p> <p>Ann E. Lee, MSW Barbara Jackson, RN, BSN Marilyn Ferguson-Wolf, MA, RD, CD</p> <p>The survey team is from: Department of Social and Health Services Aging and Long Term-Care Support Administration Residential Care Services District 2, Unit A 3906 172nd Street NE, Suite 100 Arlington, Washington 98223-4740</p> <p>Telephone: (360) 651-6850 Fax: (360) 651-6940</p> <p><i>Robin Bucknell for Mike Tornquist</i> Residential Care Services Date July 3, 2013</p>	F 000	<p>RECEIVED JUL 12 2013 ADSAVROS Smokey Point</p>	
F 241	483.15(a) DIGNITY	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Mike Tornquist</i>	TITLE Administrator	(X6) DATE 07/12/13
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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.

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F 241 SS=D	483.15(a) DIGNITY	F 241	See page 2	

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TITLE

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F 241	<p>Continued From page 1</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to promote dignified appearances which enhanced the resident's self-esteem, feelings of self-worth and individuality. This affected two (Residents #87 and #95) of 38 sampled residents. The failure placed residents at risk of having low self-esteem and or self-worth.</p> <p>Findings include:</p> <p>RESIDENT #87</p> <p>Resident #87 was admitted to the facility on [REDACTED] 07 with diagnoses which included dementia, left hemiplegia and was currently receiving palliative care. The resident was 88 years of age, was alert and was able to respond appropriately to questions asked about her basic needs.</p> <p>On 04/10/13 at 2:00 p.m., Resident #87 was observed with neck length hair, pulled up to the top of her head in a ponytail which was bound with multiple colored rubber bands. The pony tail was about an inch in height from the base of the ponytail. The bound hair was uneven in length with a few strands of the hair reaching four inches at the longest end. The ponytail was slightly bent and spiked in appearance giving a disheveled</p>	F 241	<p>This facility will promote dignified appearances for all residents to ensure enhanced self esteem and feelings of self-worth and individuality.</p> <p>The Care Guide for Resident #87 has been updated regarding her preference of not having a pony-tail type hair style. Resident #87 can no longer tolerate going to the beauty shop for a style and set. Alternative options for styling her hair will be explored with the beautician, family and resident to ensure she is satisfied with her hair style. All residents will continue to be given choices in daily care.</p> <p>The dressing to the forehead of Resident #95 was discontinued. The facility policy for dating and initialing dressings remains in place, but will be revised to state dating/initialing dressings on or around the face will not be done. This change is to promote resident comfort and dignity. Appropriate nursing staff members will be in-serviced on changes to the policy.</p>	05/31/13

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F 241	<p>Continued From page 2 appearance.</p> <p>During the same interview, when asked if she wanted her hair styled in that fashion, she stated she had not seen her hair because she did not have a mirror and was therefore unable to respond to the question. She stated she likes to wear her hair "fluffed but nice." Record review for the resident revealed a picture of her with a soft, curled, 'fluffed' hair style. Following the interview, the surveyor asked a care giving staff to take the resident a mirror.</p> <p>The care plan revealed the resident no longer went to the beauty shop to have her hair done. Instead, it was care planned the staff were to assist her in combing her hair neatly when up.</p> <p>A day later on 04/11/13 at 3:14 p.m., the resident was observed in her room. She still had a ponytail on top her head. The resident was asked if the hair style was acceptable to her. She stated she did not like the ponytail style hair-do.</p> <p>On 04/15/13 at 1:00 p.m., an interview was held with Staff I, the unit manager. She stated she had observed the ponytail and believed Resident #87 should not have a ponytail at the top of her head. Staff I stated she would speak to the care giving staff about appropriate hair styles for the elderly.</p> <p>The facility failed to promote grooming of the resident in a manner which enhanced the resident's individuality and was in keeping with her previous preferences.</p> <p>RESIDENT #95</p>	F 241	<p>Compliance with these and other dignity related issues will be part of a monthly report reviewed by the Continuous Quality Improvement committee.</p> <p>The Nurse Managers, Staff Development Nurse and Director of Nursing will monitor. The Administrator will ensure compliance.</p>	

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F 241	Continued From page 3 Resident #95 was originally admitted to the facility in [REDACTED] 08 with diagnoses including Alzheimer's, dementia and aphasia (a disturbance of comprehension and formulation of language.) The most recent Minimum Data Set (MDS) dated 02/06/13 revealed Resident #95 was cognitively impaired and was unable to communicate with staff. Resident #95 was observed to have a scab on her forehead on 04/11/13 at 8:10 a.m. The scabbed area was closer to the edge of the left eye brow and was observed to be smaller than a quarter but bigger than a dime. On the following days and times, Resident #95 was observed to have a Band-Aid type bandage on her forehead with a date clearly written across the Band-Aid: 4/11/13 at 2:45; 04/15/13 at 4:00 p.m. in the common hallway; 04/16/13 at 8:00 a.m. in the television room; and, 04/16/13 at 2:15 p.m. in the television room. An interview was conducted with administrative nursing Staff B on 04/17/13 at 10:33 a.m. She stated the facility practice was to put the date changed on skin dressings but they did not usually put the date on a Band-Aid when it was changed. An interview was conducted with Social Services Director, Staff J on 04/17/13 at 10:33 a.m. He stated he thought the dating of a Band-Aid in a visible area of a resident was a "dignity issue." He went on to state "In covered areas, yes we date the dressing" but not where it was visible to others.	F 241			

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F 253 SS=D	<p>By visibly placing a date on the Band-Aid on her forehead, the facility failed to treat Resident #95, who was unable to speak for herself, in a manner which enhanced her self-esteem and feelings of self-worth.</p> <p>483.15(h)(2) HOUSEKEEPING/MAINTENANCE</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>Findings include:</p> <p>Observation of the facility during environmental rounds conducted on 04/10/13 starting at 9:00 a.m., revealed the following:</p> <ol style="list-style-type: none"> Cracked or water logged backsplashes around the sinks located in resident rooms and/or resident bathrooms making the areas uncleanable: Rooms 228, 230, 232, 234, 237, 235, 233, 231, 229 and 225. Discolored backsplashes on the walls visible behind the toilet tank making the bathrooms unsightly: Rooms 235 and 227. 	F 253	<p>The facility will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>Each of the identified environmental issues specified under numbers 1, 2, 3, 4, 5, 6 will be repaired, painted or replaced as necessary. Appropriate staff members will be in-serviced regarding the timely reporting of any damaged, broken items or other needed building repairs. Maintenance staff will make regular inspections of all resident rooms at least monthly to identify maintenance needs. Any noted needed fixes or repairs will be evaluated by the Maintenance Director or his representative. Necessary action/repairs will be completed within a reasonable timeframe. Identification and progress on building maintenance and repairs will be reviewed at the monthly Continuous Quality Improvement meeting.</p> <p>The Maintenance Director and Housekeeping Director will monitor. The Administrator will ensure compliance.</p>	5/31/13

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F 253	<p>Continued From page 5</p> <p>3. Sink counter top laminates cracked or gouged making the areas uncleanable: Rooms 232 (no laminate left splash, 234 (no laminate right splash), and 235 (scratched).</p> <p>4. Patched, unpainted wall and ceiling surfaces making the areas unsightly and uncleanable: Room 106, wall behind the bed nearest the door. (Resident #30 indicated the wall was unsightly and it "bothered" her;) Room 230 left side of bathroom sink wall and near room sink, sanded and unpainted; Room 233, wall under sink scraped; Room 235, ceiling appears scraped from transfer pole; Room 227, hole in wall near toilet and hole in wall of room from door stopper; and, Room 225, ceiling appears scraped from transfer pole and wall behind soap dispenser unpainted.</p> <p>5. Loose, single pronged towel racks located in resident bathrooms making potential safety issues should residents grab the racks: Rooms 233, 229 and 225.</p> <p>6. Two wheelchair accommodated weight scales where the base of the scales were gouged and scraped making the surface uncleanable located in Hall A and Hall B.</p> <p>On 04/18/13 at 7:45 a.m., a review was conducted with the Maintenance Director, Staff E, of the concerns identified during the environmental rounds. He concurred the issues were the responsibility of his department and produced a list of "Work Projects" he had created in order to address issues he had seen. He stated he had only been in his position for a short</p>	F 253		

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F 253	Continued From page 6 time and "Was trying to catch up on deferred maintenance issues." When asked how long it would be to correct issues on his list, he stated "I'm not sure but soon."	F 253		
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.	F 272	The facility will conduct comprehensive, accurate assessments for each resident as required. The skin investigation for Resident #79 has been completed by the Nurse Manager on that nursing unit. Skin sheets were done for continued monitoring until the bruise was resolved. The skin occurrence report for Resident #249 has been completed by the Nurse Manager for that nursing unit. It included measuring and the initiation of skin sheets. Resident #237 has discharged. The coccyx area of Resident #7 had been monitored daily per the Medical Administration Record documentation. No skin sheet was needed as there were no open areas. This resident has discharged. In-servicing regarding skin occurrence reports, Stop and Watch reports, weekly skin check procedures, comprehensive	5/31/13

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F 272	<p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to assure four of six residents reviewed for skin had initial, periodic and complete assessment for their pressure ulcer and non-pressure ulcer skin conditions (Residents #7, #237, #79 and #249). This failure placed residents at risk for unmet skin care needs.</p> <p>Findings included:</p> <p>In an interview with Administrative nursing, Staff B, on 04/17/13 at 10:10 a.m., she reported, "A skin assessment, head to toe, is expected within 24 hours of admission. It is put on a yellow admission sheet and marked on the body (an outline of body is on this sheet) as to the location of the areas. If there are any issues, they are put on a separate skin sheet, bruises, incisions, scrapes, anything at all, along with the measurements of the area. If a bruise or skin tear, etc., is found at any time, and is not on a skin sheet, we have a skin investigation sheet. It is to find out why it happened and the areas are noted, measured and recorded. Weekly we look at those areas, measure if measurable and update the skin sheet until the areas are healed." Staff B also stated that skin investigation sheets came to her for review and she had not received any for Resident #79 and #249.</p> <p>RESIDENT #79</p> <p>Resident#79 was recently readmitted after a fall in her assisted living apartment. The Minimum Data Set (MDS) assessment from her previous</p>	F 272	<p>skin checks on admit will be given to all Licensed Nurses with Stop and Watch inservicing to include the nursing assistants.</p> <p>Weekly audit reports will be given to the Director of Nursing by Nurse Managers verifying that skin check procedures and skin sheet documentation is being done accurately and timely. Monthly reports from the Director of Nursing will be reviewed by the Continuous Quality Improvement committee.</p> <p>The Director of Nursing Services will monitor and the Administrator will ensure compliance.</p>	

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F 272	<p>Continued From page 8</p> <p>admission, dated [REDACTED] 13, indicated she needed limited to extensive assistance by one staff member for most of her activities of daily living, was alert and oriented and had multiple medical conditions.</p> <p>During dining observations on 04/11/13 at 8:20 a.m. a bruise on top of her arm, close to her elbow, was noted. The same bruise was again observed on 04/15/13 at 2:35 p.m. and was estimated to be 5 cm (centimeters) by 2.5 cm in size.</p> <p>In review of the resident's medical records the 04/08/13 (re) admission skin documentation noted "scattered small dark purple bruising to lower abdomen and a light purple big old bruise on the hip area" but no bruise was noted on her arm.</p> <p>The weekly skin check that is documented on the Treatment Administration Record (TAR) was not completed on 04/14/13 as scheduled. Staff F, the Nurse Manager, confirmed it was not completed and there was no documentation on the resident's bruised areas.</p> <p>In an interview with Staff F on 04/15/13 at 11:05 a.m., Staff F reported bruised areas are measured and marked on the "Skin Sheets." Later, at 1:05 p.m., when asked if an area the size of a quarter would be on a "Skin Sheet", she reported, "In areas that are generally vulnerable to trauma, if it is a quarter size, yes, it should be brought to the attention of someone and tracked."</p> <p>On 04/16/13 at 3:00 p.m., in review of the resident's skin sheets and medical record, no</p>	F 272			

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F 272	<p>Continued From page 9</p> <p>notation of the bruise was found. In observation of the resident, the bruise was clearly visible on her arm.</p> <p>RESIDENT #249</p> <p>Resident #249 was recently admitted to the facility following a cerebral vascular accident (stroke). Her 04/06/13 MDS indicated she was cognitively impaired, was a diabetic, required assistance of one to two staff members for activities of daily living and had other complicating medical conditions. Her medical record also indicated she could not always communicate pain or a need to reposition herself.</p> <p>On observation on 04/11/13 at 9:25 a.m., the resident had a bruised area on her right hand from the ring to about mid-way on the hand. Another bruise was noted on her wrist. The same bruising was noted on multiple days of the survey.</p> <p>The resident's 03/31/13 admission nursing assessment did not document any bruising on the resident's hand or wrist. In review of the TAR, the weekly skin check scheduled for 04/13/13 was noted completed as ordered. This omission was confirmed with Staff F on 04/15/13 at 1:00 p.m.</p> <p>At 1:05 p.m. on 04/15/13 with Staff F the bruised areas were observed. She noted they were green and purple at that time. Staff F was not sure what happened to cause the bruises and noted there should have been skin sheets documenting these bruised areas.</p> <p>In a follow up about the bruised areas, with Staff F on 04/16/13 at 1:30 p.m., she reported,</p>	F 272		

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F 272	<p>Continued From page 10</p> <p>"Typically, the aides should have reported to the nurse. The nurse should look into the areas and skin sheets started. I will do that now."</p> <p>RESIDENT #237</p> <p>In Resident #237's 02/21/13 MDS, it was indicated the resident had multiple medical problems including a recent [REDACTED] acute kidney failure, and diabetes. The resident required extensive assistance of one to two staff members for activities of daily living and was cognitively alert and oriented.</p> <p>In review of the resident's nursing admission assessment dated [REDACTED] 3, under the skin condition section, the following was noted: "3 blackened spots to left LE (lower extremity) and foot (see skin sheets)." No skin sheets were located and the initial assessment did not include information about the size, exact location or condition of these "blackened spots."</p> <p>On 02/21/13, measurements were taken for areas on the lateral 5th metatarsal, lateral left leg, medial great toe and the posterior Achilles area. Descriptions of each area were also documented. These observations and measurements were taken a week after admission, therefore no comparison as to improvement or decline from admission could be made.</p> <p>No admission skin sheets were found in a request to medical records or further documentation provided upon request from administrative nursing on 04/17/13 at 10:15 a.m.</p>	F 272		

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F 272	<p>Continued From page 11 RESIDENT #7</p> <p>Resident #7 was admitted [REDACTED] 13. The diagnoses included cellulitis to her bilateral lower extremities.</p> <p>The Braden Scale (pressure ulcer risk assessment) completed by the facility revealed the resident was at risk for pressure ulcers. He had limited mobility in bed and could not make frequent and/or significant changes positioning without assist of staff.</p> <p>The initial nursing Admission Assessment revealed the coccyx area (tail bone) was circled on the form. However, there was no documentation of a description of the area or ongoing skin tracking found for the area.</p> <p>A skin tracking sheet revealed the facility found a new pressure ulcer on the left buttock cheek area (Site "A") on 03/22/13. The area was documented as a Stage II, 0.8 x 0.6 centimeter with scant drainage. On the same skin tracking sheet, a coccyx area was documented in the comment area. It read; " redder on coccyx area, ARNP . . . notified" however, there were no other assessment documentation such as date, size and stage etc. needed to assess improvement or decline to the site.</p> <p>It was unclear whether the coccyx area was the same area identified (circled) on the initial nursing Admission Assessment or a new site. Both the coccyx area identified on admission and the coccyx area identified on the skin tracking form dated 03/22/13, had no assessment documentation. It was approximately three weeks</p>	F 272			

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F 272	Continued From page 12 after the resident admitted to the facility before "coccyx area" appeared on a skin tracking form unassessed. The treatment record for March, 2013 revealed skin checks were to be done weekly on Tuesdays, during the p.m. shift. However, the resident refused on 03/12/13 and was not re-approached for a skin check until 03/19/13. Additionally, there were no documentation of a skin assessment on Tuesday, 03/26/13. Review of the care plan dated 03/02/13 revealed the resident also had an arterial sore on her left foot, second toe. There were no skin tracking assessment documentation found for the site in the resident's record. Without an initial, periodic and complete assessment all the resident's skin conditions the resident is at risk of not having his skin care needs met.	F 272			
F 279 SS=E	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's	F 279	The facility will develop plans of care that are individualized to meet each resident's needs and to assure staff members are aware of services needed to provide observations and care. The Care Guide for Resident #197 was updated to include behaviors as well as interventions and medication use. This resident has since expired. The Care Guide for Resident #88 was	5/31/13	

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F 279	<p>Continued From page 13</p> <p>highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to use the results of the assessment to develop, review and/or revise a comprehensive plan of care for five of 38 residents whose care plans were reviewed during Stage II (Resident #s 197, 22, 88, 123 and 249). The failure placed the residents at risk of not attaining or maintaining the highest practicable well-being for respiratory, behavioral, Edema and Diabetes conditions.</p> <p>Findings included:</p> <p>RESIDENT #197, BEHAVIORAL</p> <p>Resident #197 was admitted to the facility on [REDACTED] 12. The diagnoses included dementia with agitation, urinary tract infection (UTI) and a history as a smoker. Record review revealed the resident had behavior associated with cigarette smoking cessation withdrawal. Review of the resident's most recent Significant Change Minimum Data Set (MDS) assessment dated 02/04/13 gave her a score of 10 out of 15 on the Brief Interview of Mental Status (BIMS) assessment indicating she was alert and able to make her basic needs known.</p>	F 279	<p>updated for edema.</p> <p>The Care Guide for Resident #123 was updated to include her diagnosis.</p> <p>The Care Guide for Residents #22 and #249 were updated for diabetic approaches.</p> <p>The Care Guide for Resident #22 has been updated for diabetic approaches and fluid restrictions. The approach for sliding scale insulin was removed as this resident is no longer on this medication. Approaches for shortness of breath are in place for this resident.</p> <p>Information on medications: diuretics, insulin, blood thinners, anti-hypertensives, anti-depressants, anti-anxiety medications, sedative/hypnotics, anti-psychotic medications will be placed on information sheets in all Care Guide binders. Care Guides will reference medications that residents receive and information sheets will address side effects and benefits of these classifications of medication. An information sheet on oxygen use, CPAP use, pacemaker, nebulizer and inhaler use will be placed in each Care Guide binder. Nursing assistants will be mandated to review these information sheets weekly and verify by signature that they have done so.</p> <p>All nursing staff will be in-serviced regarding the changes to the Care Guides.</p>	

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F 279	<p>Continued From page 14</p> <p>The MDS assessment dated 11/08/12 revealed the resident was admitted with physical, verbal and other behavioral symptoms directed toward others which included hitting, kicking, pushing, scratching and grabbing indicating behavior of this type occurred one to three days during the review period. When compared to the MDS assessment dated 11/15/12, behavior as stated above continued to occur one to three days during the review period. The most recent MDS assessment dated 02/04/13 revealed an increase in the resident's mood and behaviors. Behavior of this type occurred four to six days during the review period.</p> <p>The Licensed nurse progress note dated 11/11/12 revealed the care the resident required included, but was not limited to; frequent one to one activities and position change as needed to manage restless behaviors. On 04/17/13 at 1:00 p.m., the resident was observed on the unit in a one to three activity. She was eating a snack.</p> <p>Record review revealed an anti-anxiety medication was ordered three times a day on 11/13/12. A written communication to the medical care provider dated 01/15/13 revealed the resident had an increase in agitation. The resident was sent to the hospital for possible new UTI and agitated behaviors on 03/19/13.</p> <p>On 04/18/13 at 9:00 a.m., in an interview with administrative nursing Staff F, she stated when the resident would ask for cigarettes she would exhibit behaviors of agitation. Two nursing assistants (NACs), Staff G and H, were interviewed the same afternoon. Both stated the</p>	F 279	<p>The Continuous Quality Improvement committee will review compliance and effectiveness of these Care Guide changes.</p> <p>The Nurse Managers and the Director of Nurses will monitor. The Administrator will ensure compliance.</p>	

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F 279	<p>Continued From page 15 resident had behaviors.</p> <p>Record review revealed all the MDS assessments indicated a care plan was needed. However, no care plan was found consistent with the resident's specific behaviors which included measurable objectives and timetables with specific interventions to manage the resident's behaviors allegedly related to smoking cessation.</p> <p>RESIDENT #88, EDEMA</p> <p>Resident #88 was admitted to the facility [REDACTED] 12 with multiple medical conditions including several heart related conditions and edema (abnormal fluid development in the lower extremities.) Included in the medications the resident was receiving was lasix 20 mg every day for the diagnosis of Congestive Heart Failure (CHF) intended to treat the resident's fluid retention.</p> <p>Review of Resident #88's medical record revealed a care plan dated with an admission date of [REDACTED] 12 which had care planning for concerns including Cognitive Patterns, Hearing, Vision, Physical Functioning, Safety, Dressing, Personal Hygiene, Bathing, Toilet Use, Nutrition, Skin Issues, etc. None of these care planning concerns, including Physical Functioning, addressed any care planning directions related to the residents CHF and his treatment with Lasix.</p> <p>The facility failed to ensure care givers, other than licensed nurses, knew what to look for and to report related to potential side effects of lasix treatment. These potential side effects included: calf pain or tenderness, dizziness, dry mouth, loss of appetite, muscle spasms, reddish or</p>	F 279		

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F 279	<p>Continued From page 16</p> <p>purplish spots on the skin, restlessness, ringing in the ears, yellow eyes and skin or dark yellow urine.</p> <p>DIABETES</p> <p>Interviews with the Nurse Manger, Staff I, on 04/16/13 at 11:55 a.m. and with administrative nursing Staff B, were held on 04/17/13 at 10:10 a.m. Both interviews identified care plans were developed by the interdisciplinary team, with input from the resident and the family. Staff I identified the care guidelines are specific for each resident, and diabetic care and guidance should be part of the care plan so that staff know what to do for diabetic management.</p> <p>RESIDENT #22</p> <p>On Resident #22's most recent 01/22/13 MDS, it indicated she was cognitively alert, depended on one to two staff members to assist her in activities of daily living and had diagnoses which included diabetes, hypertension, heart failure, and other medical conditions.</p> <p>In review of the resident's medication administration record (MAR), it was found she received insulin for her diabetes, medications for edema/cardiac status and was on a fluid restriction, which limited the amount of liquids the resident could drink on a daily basis.</p> <p>The resident's plan of care (a document that outlines all aspects of a resident's care for nursing assistants and other care providers) did not identify the resident was a diabetic receiving insulin, was on cardiac medication and was to</p>	F 279		

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F 279	<p>Continued From page 17</p> <p>have a restriction on fluids. Goals were not identified, nor were approaches listed as to what interventions were to be used for each of these assessed care areas.</p> <p>These failures put the resident at risk for complications related to her medical condition.</p> <p>RESIDENT #249</p> <p>Resident #249 was recently admitted to the facility following a cerebral vascular accident (stroke). Her 04/06/13 MDS indicated she was cognitively impaired, was a diabetic, required assistance of one to two staff members for activities of daily living and had other complicating medical conditions.</p> <p>In an interview with the Nurse Manager, Staff F, on 04/16/13 at 3:05 p.m., she indicated the initial care plan starts on admit with a care guide. Under the section of special precautions "Diabetic" would be indicated if the person was diabetic. On the initial care plan, the resident was identified as diabetic.</p> <p>Staff F, went on to say, once all the assessments are completed for the MDS, the comprehensive care plan would be completed and it should include a section addressing diabetic management and insulin use. Staff F acknowledged there was no information related to diabetic management on this resident's current care plan despite the resident receiving insulin and was diabetic.</p> <p>RESIDENT #123, CARDIAC/RESPIRATORY</p>	F 279		
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F 279	<p>Continued From page 18</p> <p>Resident #123 had a recent change in condition which resulted in a significant change MDS on 04/12/13. This MDS indicated she had a decline in her activities of daily living, psychosocial well-being, toileting habits and her overall health status. Her medical record also indicated she recently had pneumonia and was placed on oxygen support through a nasal cannula. Her medical diagnoses included hypertension, dementia, arterial fibrillation, chronic obstructive pulmonary disease, respiratory failure, abnormal glucose tolerance, and Parkinson's disease.</p> <p>On observations of the resident during Stage 1, 04/11/13 at 10:30 a.m., through 04/16/13 at 1:15 p.m., the resident was wearing a nasal cannula with oxygen flowing into the nose piece. The physician's orders confirmed the use of oxygen with oxygen treatment starting on 04/07/13 for low oxygen saturation, shortness of breath and pneumonia.</p> <p>In review of the 04/13/13 care directives found in the resident's room on 04/16/13, (and in the resident's medical record), it included information about the use of sliding scale insulin and for the staff to be aware of the possibility of hypo or hyperglycemic reactions. The resident currently did not receive insulin treatment and did not require this type of care planning.</p> <p>These same care directives did not include information related to the resident's recent respiratory distress or use of oxygen, even though this condition started prior to the most recent care plan update. The directives also did not include information related to the resident's Parkinson's disease, cardiac status and use of a</p>
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F 279	Continued From page 19 pacemaker. On 04/16/13 at 11:50 a.m., Staff I reported the resident's care directives were in the resident's computerized medical record, hung in the closet of each resident and are mailed to the resident's family members. Additionally, a copy of the care directives were placed in a binder at the nurse's station. She acknowledged it was appropriate to include information related to the use of a pace maker in the resident's care plan.	F 279		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure one of three residents (Resident #74) received physician prescribed medications in a timely manner to meet residents expressed needs. Findings include: Resident #74 was admitted to the facility [REDACTED] 13 for rehabilitation services. According to her admission Minimum Data Set (MDS) assessment, the resident required extensive assistance of one person to perform most of her daily needs and was cognitively intact scoring a	F 309	Facility licensed staff will ensure all physician prescribed medications are received timely, given as ordered and meet each resident's expressed needs. Licensed nursing staff will follow established guidelines and protocols for obtaining orders for prescribed medications. Guidelines for calling on-call versus primary providers are posted at each nurses' station. Licensed nursing staff will be alerted to any visits to outside consultants and consultant paperwork will be sent with the resident for outside visits. Licensed nursing staff will contact each resident timely upon return from an out-of-facility appointment to process orders. Before the end of the primary provider's workday, whenever possible, the primary provider will be called for order verification. Facility staff will be cognizant of residents experiencing stress, anxiety, and/or concerns regarding all areas of their	5/31/13

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F 309 Continued From page 20
15 out of 15 on the Brief Interview of Mental Status (BIMS) assessment.

Resident #74 was interviewed on 04/11/13 at 1:55 p.m. as part of Stage I of the survey. When asked if she was currently experiencing any pain, she replied "Yes. I went to my eye doctor yesterday (04/10/13) because my right eye was running, hurt and was red." She went on to explain she had filled a prescription at an outside pharmacy for prescribed eye drops and returned to the facility approximately 4:30 p.m. with the filled prescription.

She continued, at approximately 8:00 p.m., she talked with Staff C, a licensed nurse about giving her the eye drops. The resident stated Staff C told her she could not administer the medication until she got an order from her attending physician for the prescription. The resident stated Staff C explained all prescriptions needed to be reviewed by the attending physician and Resident #74's attending physician had left the office and was not available until the following day.

Resident #74 asked Staff C if there wasn't an "emergency doctor" who could be contacted and Staff C stated "No, not until the morning." Staff C apparently also told the resident the eye drops were "prophylactic antibiotics" and as such could wait until the following morning without having any adverse effects. (Resident #74 stated she asked another staff member later if she could get her eye drops who also replied the attending physician would have to be contacted.)

Resident #74 stated "It hurt so bad I cried but

F 309

care. Exceptions to guidelines and protocols for calling on-call physicians will be made if needed to promote and ensure the psychological well-being and satisfaction of the resident. Licensed staff will be re-educated regarding sensitivity and timely response to residents' stress, anxiety or expressed needs.

Resident #74 received the full dose of antibiotic eye drop as prescribed by her optometrist and ordered by her attending physician. This resident since discharged from this facility to a lower level of care.

The Nurse Managers and the Director of Nursing will monitor and the Administrator will ensure compliance.

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F 309	<p>Continued From page 21</p> <p>they wouldn't give them to me." She went on to explain she was blind in her left eye and as such, was very concerned she might lose her vision in her right eye too. "I couldn't stand for that to happen" she stated. When asked if the facility had given her anything for the pain, she indicated they had given her a Tylenol, but it "Didn't help much." She stated she gave herself some over-the-counter eye drops finally around 1:00 a.m. which provided enough relief so she was able to fall asleep.</p> <p>Review of the resident's medical record revealed Interdisciplinary Team (IDT) Notes dated 04/11/13 at 9:26 a.m. It noted "Resid(e)nt had appt (appointment) with eye MD 4/10/13. Rec(eived) orders for eye drops. Call placed to (Staff D) and she return call this am and agreed with orders." The Medication Administration Record (MAR) documented as needed acetaminophen (Tylenol) was given to Resident #74 on 04/10/13 at 17:39 (5:39 p.m.) and at 22:19 (10:19 p.m.).</p> <p>Additionally, a physician note dated 04/11/13 was found from Staff D, which documented "Patient notes she has had some right eye pain and went to see her ophthalmologist yesterday for evaluation. She was told there was a scratch on the cornea. Received drops for the eye which has helped quite a bit." (A telephone order dated 04/11/12 for Tobramycin sulfate 0.3% solution to be administered one drop four times a day in the resident's right eye for five days was found.)</p> <p>An interview was conducted on 04/17/13 at 2:45 p.m. with Staff C, the licensed nurse whom Resident #74 had talked to concerning her eye drop prescription. Staff C stated she had called</p>	F 309		

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NAME OF PROVIDER OR SUPPLIER BETHANY AT SILVER LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 2235 LAKE HEIGHTS DRIVE EVERETT, WA 98208		
(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
F 309	<p>Continued From page 22</p> <p>the attending physician but left a message concerning the new prescription. She stated "I didn't call the on-call MD because the eye drops were a prophylactic antibiotic and did not think it was necessary to call the on-call (physician.)"</p> <p>On 04/17/13 at 1:45 p.m., an interview was conducted with administrative nursing Staff B. She stated the facility expectation was the nurse or nurse manager would contact the facility physician within an hour after receiving a new prescription in order to get the prescription filled. She stated prescribers are available "24/7" to fill telephone orders.</p> <p>A review of the facility's identified policy concerning "Medication Ordering and Receiving From Pharmacy," with an effective date of 2012, was conducted on 04/18/13. The policy under the subtitle "Emergency Pharmacy Service and Emergency Kits" stated "Emergency pharmacy service is available on a 24-hour basis . . . The dispensing pharmacy supplies emergency or 'stat' medications . . . emergency drugs, antibiotics . . ."</p> <p>The facility's failure to obtain the attending physician's order for a prescribed medication by the resident's eye doctor for approximately 14 hours resulted in Resident #74 experiencing distress and anxiety related to not having her prescription filled in a timely manner.</p>	F 309		