

AGING AND DISABILITY SERVICES ADMINISTRATION
Nursing Home Survey Report
 STATE AND CORRESPONDING FEDERAL REQUIREMENTS

1. Page 1 of 1 Pages

2. DATES OF DATA COLLECTION
3/23/16

3. NAME OF FACILITY
University Place Care Center

4. TYPE OF SURVEY
 Full Post Complaint Other: specify _____

5. TIME OF SURVEY Day Night
 Weekend Holiday

6. STREET ADDRESS
5520 Bridgeport Way West

CITY STATE ZIP CODE
Tacoma WA 98467

7. LICENSE NUMBER
1098

NOTE: According to RCW 18.51.060, the Department is authorized to deny, suspend or revoke a license and/or assess monetary fines for deficiencies cited in this report.

8.	9. WASHINGTON ADMINISTRATIVE CODES 388-97	10. CODE OF FEDERAL REGULATION 42 CFR 483.	11. FEDERAL DATA TAG NUMBER	12. REPEAT DEFICIENCY FROM SURVEY DATED	13. NEW CITATION ON POST SURVEY	14. LICENSEE'S PLANNED DATE OF CORRECTION
<input type="checkbox"/> The requirements of the following WAC's and corresponding CFR's were not met. The text of the statements of deficiencies and the licensee's plan of correction may be read on CMS form 2567, dated: <u>1/29/16</u> . **Licensee must complete column 14. <input checked="" type="checkbox"/> The following deficiencies were determined to be corrected.	-0860 (1)(b)	10(e)(1-3)	164		<input type="checkbox"/>	3/16/16
	-0640 (9)	13(c)(1)(ii)	225		<input type="checkbox"/>	3/16/16
	-0940 (1)	15 (f)(1)	248		<input type="checkbox"/>	3/16/16
	-0940 (3)(a)-(c)	15 (f)(2)	249		<input type="checkbox"/>	3/16/16
	-0960 (1)	15 (g)(1)	250		<input type="checkbox"/>	3/16/16
	-1000 (1)(b)	20(b)(i)-(xviii)	272		<input type="checkbox"/>	3/16/16
	-1920 & -1960	20(m)	285		<input type="checkbox"/>	3/16/16
	-1060 (3)(b)	25 (c)	314		<input type="checkbox"/>	3/16/16
	-1060 (3)(g)	25 (h)(2)	323		<input type="checkbox"/>	3/16/16
	-1060 (3)(i)	25 (j)	327		<input type="checkbox"/>	3/16/16
-1060 (3)(k)(i)	25 (l)(1)	329		<input type="checkbox"/>	3/16/16	
-1100 (3) & -2980	35 (i)(2)	371		<input type="checkbox"/>	3/16/16	

15. SURVEYOR'S SIGNATURE(S)

SIGNATURE <i>Sarah Hank</i>	DATE <i>3.23.16</i>	SIGNATURE <i>Loletta Maestas</i>	DATE <i>3.25.16</i>
SIGNATURE	DATE	SIGNATURE	DATE

16. LICENSEE OR AGENT

SIGNATURE OF LICENSEE (OR AGENT)	TITLE	DATE
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505473	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2016
NAME OF PROVIDER OR SUPPLIER UNIVERSITY PLACE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5520 BRIDGEPORT WAY WEST UNIVERSITY PLACE, WA 98467		
(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 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at University Place Care Center on 1/20/16, 1/21/16, 1/22/16, 1/25/16, 1/26/16, 1/27/16, 1/28/16 and 1/29/16. A sample of 38 residents were selected from a census of 86. The sample included 29 current residents and the records of 9 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>Lori Madison RN, ADN Molly McClintock BS, TRS Donna Palabrica RN, BSN Marilyn Edwards RN, MN Judy Klewicki RN, BSN Tammy Thompson, RN, BSN</p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging and Long Term Support Administration Residential Care Services, Region 3 P.O. Box 98907 MS: N27-24 Lakewood, Washington 98496-8907 Telephone: 253.983.3800 Fax: 253.589.7240</p> <p><i>Loretta Maestas</i> Residential Care Services Date <i>2/12/16</i></p>	F 000	<p>The following written allegation of compliance is intended to meet the requirements for a plan of correction under state and federal law and is not an admission that the survey findings are correct or that they rise to the level of deficiencies under applicable law.</p> <p>RECEIVED FEB 22 2016 DSHS RCS Region 3</p>	<i>3/16/16</i>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Dorinda McDonald TITLE *Administrator* (X6) DATE *2/19/16*

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 164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain 1 of 2 resident's (#84) privacy during personal care. This failure created the potential for a negative effect on the resident's psychosocial well-being related to the need for privacy and diminished quality of life.</p>	F 164	<p>F164</p> <p>All residents including Resident #84 will be provided with privacy when receiving personal care.</p> <p>The resident states that she has not observed Resident #84 when he is in his bathroom. Observation by facility staff from resident's viewpoint shows only the wall and part of the sink.</p> <p>Staff have been re-in-serviced on providing all residents with privacy during personal care to preserve dignity and quality of life as it relates to personal needs.</p> <p>The facility will conduct random resident interviews as it relates to privacy with personal care. This will be done for a period of 4 weeks and staff will be re-in-serviced based on results of interviews. Results of the interviews will be reviewed by the Quality Assurance Committee with</p>	3/16/14	

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F 164	Continued From page 2 Findings include: Resident #84 was admitted to the facility [REDACTED] 2014 with multiple medical diagnoses to include: [REDACTED] Minimum Data Set (MDS), a required assessment, dated 12/16/15 indicated Resident #84 did not walk and required 2 person assist with transferring and using the toilet. During an interview on 1/22/16 at 12:25 p.m. Resident #84 said sometimes the staff did not close the door to the resident room or the bathroom when s/he was taken to the bathroom. According to Resident #84 s/he had to use call light to have staff come back to close the doors. On 1/26/16 at 12:59 p.m. Resident #84's room was observed to be empty with the wheelchair positioned near the recliner. The bathroom door was open approximately 2 inches and the bathroom light was on. On 1/26/16 at 1:04 p.m. staff were observed entering Resident #84's bathroom. A resident sitting in hallway across from Resident #84's room called out to the Nursing Assistants to "shut the door" when they were going to assist Resident #84 out of the bathroom. The resident in the hallway stated "I don't like it when I'm eating and they leave the door open." This resident was sitting in direct line of sight into Resident #84's bathroom. Failure to provide privacy during provision of care	F 164	F164 continued recommendation as appropriate. Director of Nursing, as well as Nurse Managers will monitor for compliance.	

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F 164	Continued From page 3 placed residents at risk of diminished dignity and quality of life related to not having privacy needs met.	F 164			
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance	F 225	F225 Both Staff D and Staff E have current criminal background check results. Audits of all employee criminal background checks have been completed. No other backgrounds were found to be out of compliance. All new employees will be required to complete a criminal background check prior to the employee's start date. During the initial hire employment, new employees are supervised during their orientation period. The payroll clerk will maintain a tickler system and monitor the background checks for all newly hired employees. If there are any discrepancies, the payroll clerk will contact the	3/16/16	

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F 225	<p>Continued From page 4 with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure criminal background checks were completed before hire for 2 of 5 employees. Failure to thoroughly investigate the backgrounds of newly hired employees placed residents at risk for mistreatment.</p> <p>Findings include:</p> <p>On 1/27/16, a review of the facility's "Employment Screening Policy and Procedure" dated 01/2009, revealed "All individuals who are interested in obtaining employment must complete the application packet" which included the background check request. The objectives for completing the packet were to determine if the applicant met criteria for employment and to screen applicant for criminal history through completion of the background check.</p> <p>Review of employee records on 1/26/16 revealed Staff D (housekeeping) was hired on 7/30/15 and started employment on 8/4/15. A fax confirmation of a request for a background check was dated 8/4/15. Completed background check from Background Check Central Unit (BCCU) was dated 8/12/15.</p>	F 225	<p>F225 continued</p> <p>Administrator to resolve the issue.</p> <p>The Administrator will report the results of the audits to the quality assurance committee for further review.</p>		

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F 225	Continued From page 5 Staff D worked with unsupervised access for approximately one week until the background check was received. Review of Staff E's (housekeeping) employee record revealed s/he was hired on 9/24/15 and started employment on 9/28/15. A fax confirmation of a request for a background check was dated 9/30/15. Completed background check from Background Check Unit (BCCU) was dated 10/3/15. The background inquiry was initiated two days after the staff started working. By the time the results returned, Staff E had worked with unsupervised access for approximately one week until the background check was received. In interview on 1/26/16 at 12:49 p.m., Staff C stated background checks should be submitted before a potential employee was hired. S/he stated typically a request would be submitted and then wait for results of the background check before a person would start working. In interview on 1/26/16 at 1:39 p.m., Staff A stated potential employees would fill out the background check request after a job offer was made and the request was then sent to BCCU. A potential employee could start work once a request was faxed, pending the results of the background check. Staff A further stated Staff E's background check request should have been submitted on or prior to his/her start date.	F 225			

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F 225	Continued From page 6 Staff A allowed new employees to work unsupervised before receiving background check results.	F 225			
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide or encourage leisure activities for 2 of 2 cognitively impaired sample residents (#55, 67) reviewed for activity participation, which resulted in extended periods of time without significant interaction or meaningful activities in accordance with assessed needs, current or past interests. Failure to provide physical, emotional or mentally stimulating contact placed the residents at risk for social isolation, lack of stimulation, further cognitive decline, increased behaviors, and decreased quality of life. Findings include: RESIDENT #55 Record review of Resident #55's 4/17/15 Minimum Data Set (MDS), an assessment tool,	F 248	F248. Resident #55 is no longer a resident of the facility. The care plan for Resident #67 was updated to reflect the resident's activity preferences and interests. The Activity staff are following the visitation schedule per the care plan. The care plans for all residents that have been identified in-room visits have been reviewed and updated. The visitation schedule for in-room visits was revised to include the number of days per week each room bound resident will receive visits. The Activity staff have been in serviced regarding the in-room visitation schedule, the leisure cart schedule and	3/14/16	

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F 248	<p>Continued From page 7 revealed the resident was admitted on [REDACTED] 15 with diagnoses including [REDACTED]. The resident required 1 to 2 staff members for all activities of daily living (ADL's) and mobility. The resident presented with moderate to severe memory loss and disorientation, trouble concentrating and spoke with [REDACTED]. According to the MDS, the resident did not demonstrate behaviors or report pain.</p> <p>The initial 4/17/15 MDS Activity assessment reported Resident #55 felt the following activities were very important to him/her: reading books and newspapers, keep up with current events, involvement with pets, choose own bedtime, choose what clothes to wear, take care and keep belongings safe, listen to choice of music, getting outside for fresh air on nice days and being able to participate in favorite activities.</p> <p>In interview on 1/21/16 at 11:00 a.m., an attempt was made to interview Resident #55. He was pleasant, stated [REDACTED] name and that s/he was "waiting," but did not elaborate. Observations on all days of the survey revealed no group or individual participation in facility activities. The resident was observed sitting up in his/her wheelchair in the hallway with minimal staff interaction, or sleeping in his/her room, 2 occasions with music on. The resident had a private room.</p> <p>Record review of document titled, "Initial Activity Assessment/Care Plan" dated 4/18/15 revealed the resident preferred independent activities including reading, visiting and "easy to talk to," meaning enjoyed one to one (1:1) interactions.</p>	F 248	<p>F248 continued</p> <p>following the plan of care for all residents.</p> <p>The Activity Consultant will audit the care plans for residents quarterly.</p> <p>The Activity Consultant will provide the results of the audit to the quality assurance committee for further review.</p> <p>The Administrator will monitor for compliance.</p>	

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F 248	<p>Continued From page 8</p> <p>Risk factors included communication difficulties and lack of family support. The resident retired from the military and used to be a dog handler. No goals were identified. The Assessment/Care Plan had not been updated since admission.</p> <p>Record review of the care plan dated 12/4/15 revealed Resident #55 had impaired cognitive function [REDACTED] or impaired thought processes related to short and long term memory loss, [REDACTED] and behaviors/yelling and restlessness. Interventions included engaging the resident in simple, structured activities avoiding overly demanding tasks. The care plan did not identify what the resident preferred. In addition, the resident was identified with a history of [REDACTED]. One intervention added 9/8/15 included providing the resident with a program of meaningful activities and of interest, such as sitting in the hall socializing with staff, 1:1 activities, and visits from friend.</p> <p>The activity calendar and participation record for Resident #55 revealed, the resident actively participated in half of the activities the staff attempted to engage the resident in, between October 2015 and January 2016.</p> <p>Review of the participation record revealed a total of 9 opportunities for activities for the month of October 2015. Two opportunities for sports on television, three opportunities for group BINGO, and five for one on one visits from a volunteer, activity staff or friend. Out of the 9 opportunities, the resident refused 3 Bingo games and a football game on television in a group. The resident was unavailable or sleeping for 4 of the offerings.</p> <p>Staff offered group activities to the resident,</p>	F 248		

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F 248	<p>Continued From page 9</p> <p>however the resident preferred 1:1 activities. In addition, staff did not establish the resident's preferred routine to determine if the resident preferred to sleep certain times of day.</p> <p>The resident participated in four 1:1 visits from activity staff or friend for conversation in October 2015. There were no measurable goals related to the number of activities the resident was expected to engage in for October 2015.</p> <p>The participation record revealed 15 opportunities for activities for November 2015. The resident refused two Bingo games, unavailable for five opportunities and actively participated in 8 activities including one matinee and seven 1:1 visits.</p> <p>A few additional hand-written, informal notes were provided, but did not describe the resident's response to all activities, and no activity progress notes available in the resident's chart. Staff H said the activity department needed to improve on documentation.</p> <p>In interview on 1/28/16 at 11:28 a.m., the Power of Attorney (POA) said the resident had a poor attention span, impaired judgement, had multiple falls in the facility, did not like groups of people, and preferred 1:1 conversations. The POA came to visit weekly and did not often see the resident in activities in the facility. S/he stated the nursing assistants eventually figured out that Resident #55 enjoyed country-western music, which helped calm him/her.</p> <p>In interview on 1/28/16 at 12:13 p.m., Staff H stated s/he was not "clinically" experienced. According to Staff H, residents who were</p>	F 248		

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F 248	<p>Continued From page 10</p> <p>identified as a fall risk sat in tilt-and-space wheelchairs, positioned tilted back. In addition, Staff H explained, when attending activities, an activity staff would sit next to the resident because the wheelchairs would not fit at the tables.</p> <p>Staff did not accomodate reisdents to sit directly at the tables to actively engage and enjoy activites.</p> <p>When asked if Staff H considered sitting the residents up in the wheelchair at the table in a standard fashion, Staff H stated it was not up to him/her, that it was up to the nursing assistants.</p> <p>Staff H did not have the ability to make adaptations to meet the residents' indivudual needs to enjoy and actively participate in activites.</p> <p>In futher interview, Staff H stated the Activity Department's primary focus was to conduct group activites.</p> <p>According to Staff H, Resident #55 was in a tilt-and-space wheelchair and did not like to attend group activities and became disruptive during them. Although the resident did not like group activites, staff continued to engage the resident in group activities.</p> <p>According to Staff H, residents in tilt-back chairs did not receive direct intervention because s/he was tilted back. Staff H explained Resident #55 used to say hello to everyone, wanted you to say hello back, and wanted someone to listen. Staff H said the resident enjoyed history, was proud of his [REDACTED] heritage, talked about [REDACTED] experiences, enjoyed reading, animals and</p>	F 248		

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

PRINTED: 02/12/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505473	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2016
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F 248	<p>Continued From page 11</p> <p>occasional religious service visits, and was easy to talk to.</p> <p>In futher interview, Staff H said Resident #55 started demonstrating behaviors and was difficult to keep his/her attention. The resident's condition changed and no longer carried on a conversation.</p> <p>Staff H knew the resident, was aware that s/he did not engage in group activites, and did not provide the physical, emotional or mentally stimulating contact to meet the resident's psychosocial needs.</p> <p>RESIDENT #67 Resident #67 admitted to the facility in [REDACTED] 2008 with multiple medical diagnoses to include [REDACTED]</p> <p>The Minimum Data Set (MDS), an assessment tool, dated 12/22/15, indicated activity preferences were very important. Activities prefered were reading books, newspapers and magazines; listening to music and being around animals such as pets. Resident #67 required total assistance with care (did not participitate in care).</p> <p>Review of the care directive dated 1/18/16 located in Resident #67 closet listed activities: 1:1 activities in room, enjoys music, 1:1 story time or showing pictures, CD player on periodically, sensory stimulation with scents.</p> <p>A review of a Social Service care plan dated 6/10/15 for Resident #67 revealed psychosocial interventions included offering 1:1 activities. In addition, Resident #67 was documented to</p>	F 248		

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

PRINTED: 02/12/2016
FORM APPROVED
OMB NO. 0938-0391

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F 248	<p>Continued From page 12</p> <p>respond well to having music played in room. The Activity Care Plan dated 4/15/10 listed the intervention to provide 1:1 visits at least twice per week. According to the family of Resident #67 previous interests included such things as house cats and other animals, listening to classical music, listening to country western music and being read to.</p> <p>In an interview on 1/27/16 at 2:50 p.m. Staff H reported that leisure checks were done on every hall twice a week and involved taking the Activity cart to every room to see what residents would like or need. Activities for bed bound residents included things like sensory stimulation, aroma therapy, sound machine, tactile things for touching, pictures memories, 1:1 visits, reading. Staff H stated it was activity staff were responsible to ensure that music was played if care planned as an activity. S/he further stated activity staff provided Resident #67 with soft music, sat and talked with the resident and put items in the resident's hands to grasp or feel, for tactile stimulation activity.</p> <p>A review of Hospice Comfort Therapy notes dated 1/7/16 revealed, "patient moved arms as soon as I started playing, mumbled a few times during the session, closed her eyes for a few minutes at a time as I played soothing music on the harp and a few minutes of singing bowls which she listened to intently." A second note dated 1/16/16 revealed, "staff communicated that resident was enjoying the music and would take a pause from eating as I played the soothing music."</p> <p>On 1/25/16 at 12:45 p.m. Resident #67 was observed in bed with eyes open. A CD player was placed on the sink counter with a music CD</p>	F 248			

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

PRINTED: 02/12/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505473	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2016
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F 248	<p>Continued From page 13</p> <p>sitting on top. A box of isolation face masks was placed on top of the CD player and CD.</p> <p>During observation on 1/25/16 between 2:00 p.m. and 3:00 p.m., it was noted that leisure checks were conducted for residents on 100 and 200 hall did not include a visit to Resident #67's room.</p> <p>On 1/26/16 at 11:01 a.m. Resident #67 was observed in bed. The CD player remained untouched in the same position on the sink counter.</p> <p>A third observation on 1/27/16 at 11:16 a.m. revealed, Resident #67 was in bed with eyes his/her playing with the bed sheets. The CD player remained on the sink counter and appeared unchanged from the past few days.</p> <p>On 01/28/2016 at 9:13 a.m., the CD player was observed sitting on the counter, a CD placed on it, and a box of isolation masks on top of the CD. The CD player appeared untouched from prior observations.</p> <p>On 01/28/2016, continuous observations between 11:00 a.m. and 12:00 p.m. revealed no leisure checks were performed on the 100 hall.</p> <p>In an interview on 1/26/16 at 12:18 p.m. Staff K reported Resident #67 did not participate in any facility activities. However, Hospice staff occasionally played harp music.</p> <p>In an interview on 1/26/16 at 1:47 p.m. Staff F reported volunteers read to Resident #67 and activity staff visited residents that were bed bound or did not go to activities.</p>	F 248			

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

PRINTED: 02/12/2016
FORM APPROVED
OMB NO. 0938-0391

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F 248	Continued From page 14 Record review of the activity care plan and participation calendar revealed, Resident #67 had 3 visits in January 2016. One of the visits included dropping off the activity calendar. In December 2015 the resident had 7 leisure checks. According to the documentation, there was no indication that CD player or other music was provided as an activity. Offering music did not require participation of the resident and raised the question why music, as the resident preferred, was not provided. The facility's failure to provide meaningful activities to a bed bound resident, which had been identified as pleasurable, placed the resident at risk for decreased quality of life.	F 248			
F 249 SS=D	483.15(f)(2) QUALIFICATIONS OF ACTIVITY PROFESSIONAL The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the State in which practicing; and is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or is a qualified occupational therapist or occupational therapy assistant; or has completed a training course approved by the State.	F 249	<u>F249</u> The facility will employ a qualified Activity Director per regulations to provide direction for the development, implementation, supervision and ongoing evaluation of the residents' participation and activities program that contributes to and/or meet the interests/preferences of each resident.	3/16/16	

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

PRINTED: 02/12/2016
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F 249	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a qualified professional provided direction for the development, implementation, supervision and ongoing evaluation of the residents' participation and activities program that contributed to and/or met the interests/preferences of each resident. This failure created the potential to impact residents' physical abilities, social well-being and quality of life. Findings include: In interview on 1/28/16 at 12:13 p.m., Staff H stated s/he was the Activity Director at the facility, had previously worked as a concierge in a hospital, and was not certified or licensed. Staff H said s/he was not currently enrolled in classes and was not involved in a formalized training program that met state or federal requirements. The facility hired an activity consultant who visited the facility once a month to review the case load and make suggestions. In interview on 1/28/16 at 4:30 p.m., Staff A stated the Activity Director did not have credentials and was not certified, however there was a contracted consultant in once a month. Staff A was not certain that having a contracted consultant for the department met the criteria for Activity Director.	F 249	F249 continued The facility Certified Activity Consultant will continue to train and guide the activity staff. Additionally, the consultant will provide direction and implementation of the activities program. The Administrator is responsible for compliance.		

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

PRINTED: 02/12/2016
FORM APPROVED
OMB NO. 0938-0391

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F 249	Continued From page 16 The consultant did not meet criteria as s/he did not provide ongoing assessments and evaluate residents' response to activities. Refer to F 248.	F 249			
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide medically related social services for 2 of 2 residents (#55, 67) when investigated in Stage 2. The facility failed to respond to behavioral symptoms to find options to meet the physical and emotional needs of each resident. Failure to address the behaviors placed the residents at a potential risk for not attaining or maintaining the highest practicable level of physical, mental, and psychosocial well-being. Findings include: 1. Refer to F323 for facility failure for the resident environment was free of accident hazards 2. Refer to F329 for facility failure for the	F 250	F250 Resident #55 is no longer a resident of the facility. The care plan for Resident #67 was updated to include instructions for staff to open the blinds and privacy curtain when the resident is awake. Additional items have been added to the resident's room to personalize the environment reflecting his/her past interests. The Interdisciplinary Team (IDT) will conduct monthly behavior meeting to discuss residents that have been identified with behaviors. The review will include determining root cause of the behavior and update the care plans as needed.	3/16/14	

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

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OMB NO. 0938-0391

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F 250	<p>Continued From page 17 resident to be free from unnecessary medications</p> <p>RESIDENT #55 Record review of the 4/17/15 Initial Minimum Data Set (MDS), an assessment tool, revealed Resident #55 was alert with moderate to severe memory loss, impaired judgement, and required assistance of 1 to 2 staff for all activities of daily living (ADL's) and mobility. According to the MDS, the resident was incontinent of bowel and bladder, a high fall risk, did not exhibit mood or behavioral issues. Diagnoses included [REDACTED]</p> <p>[REDACTED] Medications included 2 [REDACTED]</p> <p>Review of Social Services Admission Evaluation dated 4/13/15 revealed Resident #55 was a retired [REDACTED] worked as [REDACTED] and trained dogs. The resident had [REDACTED] children, who were estranged for more than 15 years, and the resident had a social history of several "failed" marriages. The resident was proud of his/her [REDACTED] heritage played the [REDACTED] and other instruments for enjoyment. The Power of Attorney (POA) came to visit weekly for support. The resident had a history of [REDACTED] and poor coping skills. The resident preferred to participate in one to one (1:1) activities and socialization.</p> <p>Social Service progress note dated 4/16/15 revealed Resident #55 was alert and oriented to self, place and general time, able to make needs known, communication easily understood and no mood or behavioral issues. Staff reported the resident was unwilling to participate in the</p>	F 250	<p>F250 continued</p> <p>Social Services staff will coordinate with the resident and family regarding personalizing the residents' room upon admission and/or during care conferences.</p> <p>Social Services staff will also participate in the review of resident accident/incidents to support the IDT with root cause and prevention of further incidents.</p> <p>Social Services staff will report to the quality assurance committee regarding the status of the residents with behavior issues.</p> <p>Administrator will monitor for compliance.</p>		

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F 250	<p>Continued From page 18</p> <p>cognitive and mood assessments at that time.</p> <p>Record review of the MDS dated 7/14/15 revealed Resident #55 exhibited worsened behavioral symptoms, to include verbal outbursts and physical aggression toward staff.</p> <p>Social Service quarterly progress note dated 7/20/15 revealed Resident #55 was alert to self, place and time was "general." In addition, the resident exhibited confusion, sustained several falls, episodes of "hysterical crying," behaviors such as throwing coffee, combative with staff, called 911 to be taken home. A urine analysis (UA) was obtained with no [REDACTED]</p> <p>No potential causes identified for the behaviors, falls, or change in condition mentioned in the summary. No discussion of having consulted with various departments or POA to attempt to identify any unmet needs.</p> <p>Mental health referral was made and evaluation performed on 7/22/15. The resident told the psychiatrist that the interview was over and to "get out of here." Only medication changes were recommended at that time; no recommendations for approach or other non-medical interventions were mentioned.</p> <p>Review of care conference notes dated 7/31/15 revealed Resident #55 continued to exhibit behaviors, refusing therapy participation, history of choking (recommending honey thick liquids and sitting upright), and experienced more episodes of falling. Effectiveness of interventions and potential root causes to the behaviors and falls were not discussed with the POA, or identified by nursing, the activity department or social work.</p>	F 250			

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

PRINTED: 02/12/2016
FORM APPROVED
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F 250	Continued From page 19 Social Service progress note dated 8/17/15 revealed a change in staff in the social work department and a different social worker was to follow. Social Service progress notes dated 10/12/15 revealed Resident #55 had poor verbal ability and staff anticipated his/her needs. According to Social Service notes, the resident did not exhibit mood or behavioral issues. However, it was discussed that target behaviors that were exhibited "appeared to be anxiety induced." It was unclear what the target behaviors were, how the conclusion was determined, what the cause of the anxiety was, and what interventions were effective. According to the incident report log, the resident had 26 falls between July 2015 and December 2015. The facility and Social Service did not discuss or address potential causes for the falls. Review of behavior monitors July 2015 to January 2016 revealed licensed nurses did not complete any of the monitors to include frequency of target behaviors exhibited, interventions performed or effectiveness of interventions to determine root cause, triggers, trending with times of day, activities, or if a medical condition potentially contributed. The facility did not consistently document or monitor behaviors. Review of the mood and behavioral care plan dated 9/8/15 revealed no individualized interventions specific to Resident #55 and was not updated to reflect ineffectiveness of the medical and non-medical interventions attempted.	F 250			

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

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F 250	Continued From page 20 In interview on 1/28/16 at 10:30 a.m., the POA said the Resident #55 blamed him/her from the beginning for being in the facility because s/he "drove" him/her there. The resident never adjusted to being in the facility, had suffered from [REDACTED] for many years. S/he had several marriages and did not have a relationship with his/her [REDACTED] children. He got in to the [REDACTED] at 14 years of age because his/her home life was abusive. The [REDACTED] raised him. The POA believed the resident had sundowners, and according to the resident "everyone was in a conspiracy against" him/her. The POA stated the resident had asked him to bring his gun in one time, but the resident did not mention why. In addition, the resident had been in and out of several facilities. S/he didn't like any of them and they had a difficult time with him/her. According to the POA, it was never determined why the resident fell so many times. The POA believed the resident was attention seeking, which was rewarded when everyone came running. In interview on 1/28/16 at 12:30 p.m., Staff N stated the social service's role in the facility was to work the with the resident, families, create behavior monitors for nursing staff to complete and present the information at the [REDACTED] medication review meetings. Care conferences and referral information was also brought to the psychotropic review meetings. If a resident was not on a psychotropic medication but exhibited behaviors, then that resident would not be reviewed at those meetings. Staff N was uncertain of a meeting that those residents would be discussed to determine the causes of the behaviors other than care conferences. In addition, Staff N also reported residents with	F 250			

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

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FORM APPROVED
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F 250	<p>Continued From page 21</p> <p>cognitive impairments demonstrated behaviors at times that indicated needs were not being met, such as refusing meds or care, verbally abusive or yelled. Staff N did not have Resident #55 on case load.</p> <p>Staff N was aware of the behavior monitors not being completed consistently.</p> <p>In interview on 1/29/16 at 12:34 p.m., Staff Z stated s/he had only been employed with the facility since January 7, 2016 and was still getting to know the residents, including Resident #55. The interaction s/he had with the POA and the resident was at the care conference on 1/25/16, after the decline the resident recently exhibited. The POA declined a chest x-ray for the resident, requested a Hospice referral, wanting the resident to be kept comfortable related to end of life.</p> <p>The facility did not address Resident #55's possible adjustment issues, attention seeking behaviors, multiple falls, refusals, hysterical crying episodes, yelling and outbursts. The facility did not assess or determine potential root causes for the falls or behaviors exhibited.</p> <p>RESIDENT #67 Resident #67 was admitted [REDACTED] 2008 with multiple medical diagnoses to include [REDACTED]. [REDACTED] The resident was bed bound and unable to participate in activities outside of the room.</p> <p>A review of Psychosocial Well-Being Care plan initiated 6/10/15 and revised 12/23/15 included interventions to encourage room personalization to maintain Resident #67's identification with past</p>	F 250			

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

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OMB NO. 0938-0391

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F 250	<p>Continued From page 22 roles and life status.</p> <p>On 1/25/16 at 12:45 p.m. Resident #67 was observed in bed facing the privacy curtain that was pulled between the residents beds. Bed was positioned against the wall facing the door making it impossible to see past the pulled privacy curtain. Window blinds were pulled down and there were no pictures on the wall, giving the room the appearance of being dark and stark.</p> <p>In interview on 1/26/16 at 12:18 p.m. Staff K stated Resident #67 used to be in room [REDACTED] and there were no personal belongings there.</p> <p>Interview on 1/26/16 at 1:47 p.m. Staff F said Resident #67 had a room change over a year and a half ago because family wanted a window bed. The resident did not get out of bed due to the anxiety it caused and the family's wish for comfort care. According to Staff F, the resident's room was never personalized, had not informed the family regarding bringing in personal items.</p> <p>On 1/26/16 at 11:01 a.m. and 1:11 p.m. Resident #67 was observed in bed with eyes open. The window blinds were down covering the window. The privacy curtain between the beds was pulled. The overhead lights were off.</p> <p>On 1/27/16 at 11:16 a.m. Resident #67 was observed in bed with eyes open. The window blinds were open and the window was open about 2 inches. The privacy curtain was pulled to cover half of the window nearest the Resident #67's bed. The privacy curtain between the beds was pulled.</p>	F 250		

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

PRINTED: 02/12/2016
FORM APPROVED
OMB NO. 0938-0391

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F 250	Continued From page 23 In an interview on 1/27/16 at 2:28 p.m. Staff F reported being unclear how the care plan regarding room personalization came about. The care plan was reviewed with Staff F and it was determined it was initiated by Social Services. Staff F believed Activities or Social Services would help with personalizing a room if family did not. In interview on 1/27/16 at 3:22 p.m. Staff N stated the care plan regarding personalizing room is a "typical one I put in, I was taught to include that in the care plan when I started here." Staff N stated s/he had been Resident #67's Social Worker for a couple of years and reported "I haven't been in the resident's room lately and when I have it's been to talk to the roommate." Resident #67 had been in a different room and had things in the other room. Staff N did not know why items did not go to the current room. Staff N stated the room change occurred "over a year, maybe a year and a half ago." Failure to ensure the resident's need to live in a home-like environment placed the resident at risk for a potential negative impact on the resident's mental and psychosocial well-being.	F 250			
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 272	F272 The facility will continue to conduct initial and periodic comprehensive, accurate, standardized reproducible assessments of each	3/16/16	

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F 272	<p>Continued From page 24</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (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 on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure minimum data set (MDS) assessments were correct to list all active diagnoses in order to identify, treat and</p>	F 272	<p>F272 continued</p> <p>resident's functional capacity.</p> <p>The MDS for Resident #100 dated 12/15/15 and 12/21/15, has been revised and the diagnosis of [REDACTED] has been added to the active diagnosis list.</p> <p>Resident #100 as well as all residents will be assessed initially upon admission, quarterly and as needed for depression. Section D of the Minimum Data Set assesses for Resident Moods based on resident interview and/or staff observation. Resident # 100 was assessed on 12/15/15 and there were no observation of sign and symptom of a mood disorder.</p> <p>The MDS for Resident #84 dated 11/1/15 has been modified to reflect oral/dental status. Resident #85 denies any dental concerns. Oral health is reflected on plan of care.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 272	<p>Continued From page 25</p> <p>provide appropriate care and services to 2 of 38 residents (#s 100, 84) reviewed. This failure placed residents at risk for inadequate or ineffective care, treatment and interventions and follow up for existing medical conditions.</p> <p>Findings include:</p> <p>RESIDENT #100 Resident #100 was admitted to the facility on [REDACTED] 15. The Minimum Data Set (MDS) Admission Assessment (a required assessment tool) dated 12/15/15 did not check diagnosis in Section I, Active Diagnosis of a psychiatric or mood disorder.</p> <p>Review of the hospital discharge summary records dated [REDACTED] 15 document the resident received [REDACTED] an antidepressant during the hospital admission.</p> <p>Record review of Provider notes dated 12/8/15 included among the list of diagnosis, [REDACTED]. Further review of Resident #100 clinical records reveal this was the only diagnosis list that included [REDACTED] as an active diagnosis.</p> <p>The Admission Record recorded diagnosis of [REDACTED].</p> <p>[REDACTED] Also there was not documentation to show the resident was assessed for [REDACTED].</p> <p>Additionally, the preadmission screening and resident review (PASRR) did not identify any serious mental illness in Section I of the form that was completed by the hospital, and was not</p>	F 272	<p>F272 continued</p> <p>All residents will be reassessed as part of the quarterly assessment to ensure an accurate assessment of dental needs and oral care will be reflected on each resident's care plan as appropriate.</p> <p>Licensed Nurses completing MDSs will be in-serviced regarding the accuracy of the MDS to include active diagnosis and oral/ dental status and ensuring this is reflected on the resident's plan of care as appropriate.</p> <p>MDSs will be audited weekly for oral status and mood/psychiatric disorders identified as appropriate for a period of one month.</p> <p>Results of the audits will be reviewed by the Quality Assurance Committee with further recommendations as appropriate.</p> <p>Director of Nursing will monitor for compliance.</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 272	<p>Continued From page 26</p> <p>corrected by the facility on or following admit, although the resident was receiving an antidepressant for [REDACTED]</p> <p>No evidence was found in the resident's records to support the use of [REDACTED] beyond having it on admit to the facility. A review of the residents records to ensure a thorough assessments was completed to identify appropriate treatment and interventions needed, was not done.</p> <p>RESIDENT #84 Resident #84 was admitted to the facility [REDACTED] 2014 with multiple medical diagnoses to include [REDACTED]</p> <p>Minimum Data Set (MDS), a required assessment, dated 11/01/2015 indicated no dental issues under section L. Comprehensive MDS dated 8/5/15 also indicated no dental issues.</p> <p>Admission Data Collection and Assessment form dated 12/10/15 reviewed and Resident #84 identified to have missing, broke, carious teeth.</p> <p>On 1/21/16 at 11:39 a.m. Resident #84 was observed to be missing multiple upper and lower teeth.</p> <p>The November 2015 care plan review revealed no dental care plan in place to address resident specific dental care needs. A generic care plan was found for independent daily oral care.</p> <p>During an interview on 1/26/16 at 12:53 p.m.</p>	F 272			

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F 272	Continued From page 27 Resident #84 stated " Of course I'd like to have these pulled and get dentures" S/he reported oral pain only if a tooth breaks off. In an interview on 1/28/16 at 2:33 p.m. Staff L stated the questions in the MDS were followed when completing the dental section. Staff L reported she looked in Resident #84's mouth and asked if s/he was having discomfort or oral pain. Staff L reported charts are reviewed when completing every MDS. Failure to accurately assess the dental status of the resident placed the resident at risk of having potential unmet oral health needs.	F 272			
F 285	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2) (i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and	F 285	F285 The facility will continue to ensure that the Preadmission Screening Resident Review (PASRR) is accurate to include diagnosis of mental health. The PASRR for Resident #100 has been reviewed and corrected with referrals made as indicated. All PASRRs will be reviewed upon admission and quarterly to for accuracy. Resident's	3/16/16	

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F 285	<p>Continued From page 28</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>(ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission--</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>For purposes of this section:</p> <p>(i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1).</p> <p>(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure the preadmission screening resident review (PASRR) was accurate to include diagnosis of mental illness for 1 of 5 residents (#100) reviewed for PASRR. This failure resulted in the resident not receiving appropriate referrals and assessments to determine the potential needs for specialized care and services.</p> <p>Findings include:</p> <p>Resident #100 admitted to the facility on [REDACTED] 15</p>	F 285	<p>F285 continued</p> <p>orders for psychotropic medications and/or mental health evaluation during stay at facility will have PASRRs reviewed at the behavior/psychotropic committee meeting to ensure PASRRs are updated as appropriate.</p> <p>Social Services will be in-serviced on reviewing PASRRs upon admission and quarterly and with the instatement of psychotropic medication.</p> <p>Random audits will be completed on PASRRs on-going and findings will be presented to the Quality Assurance Committee with recommendations as appropriate.</p> <p>Administrator and Director of Nursing will monitor for compliance.</p>	

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F 285	<p>Continued From page 29 with diagnosis to include [REDACTED]</p> <p>[REDACTED]</p> <p>Record review of the hospital discharge summary dated [REDACTED] 15 lists [REDACTED] an antidepressant as one of the medications the resident had received in the hospital and continued when transferre to the facility.</p> <p>In addition, the facility provider note dated 12/8/15 documented the resident with a diagnosis of [REDACTED]. Though the use of an antidepressant was listed in the resident's medical records and a diagnosis of [REDACTED] was recorded in the provider notes, the PASRR was not corrected to reflect appropriate diagnosis and a referral.</p> <p>In interview on 1/28/16 at 3:30 p.m., when asked about the PASRR review process, Staff N said "every resident has to have one to come here. I want to make sure everyone is current. If they are on [REDACTED] they have [REDACTED]". Staff N further stated "if there is a change in condition, we can always have PASRR person come in and look at resident if any concerns."</p> <p>Resident #100 admitted to the facility with [REDACTED] prescribed and a related diagnosis of [REDACTED]. The PASRR received from the hospital did not list [REDACTED] as an indicator and the error was not identified and correct by the facility. For this reason the resident did not receive referrals and evaluations to determine possible need and specialized services.</p>	F 285			

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

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F 314 F 314 SS=D	Continued From page 30 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure an existing wound was monitored and treatment provided to prevent worsening for 1 of 3 residents (# 15) reviewed for pressure sores. This failure placed residents at risk for decreased healing, development of new sores with pain and discomfort and a decreased quality of life. Findings include: Resident #100 (closed record) admitted to the facility on [REDACTED] 15 with diagnoses of [REDACTED] Review of the Skin Condition Sheet dated 10/22/15 indicated the resident was admitted with a [REDACTED] amputation with sutures intact and slight	F 314 F 314	F314 The facility will continue to monitor all existing wounds and provide treatment to prevent worsening of pressure sores. Review of Resident #100's medical record indicates there has not been any pressure sores since admission to this facility. All residents with pressure sores will have at least weekly, or more frequently as needed, assessment and documentation in the resident's medical record. Audits will be completed weekly on residents with pressure sores. Finding will be brought to the Quality Assurance Committee with recommendations as appropriate based on audits. Director of Nursing or designee with monitor for compliance.	3/16/16

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 314	<p>Continued From page 31</p> <p>swelling around the site and a small open area with a partial scab on the [REDACTED] heel.</p> <p>Review of Admission Nursing Progress Notes (NPN) dated 10/22/15 revealed the "resident wears protective boots on bilateral lower extremities (BLE). Has a small open, partially scabbed area on bottom of [REDACTED] heel." A NPN on 10/23/15 documented "heel protectors on."</p> <p>Record review of the Resident #100 clinical chart revealed no further documentation in the nursing notes of any assessment of the [REDACTED] heel wound until 11/5/15. An entry dated 11/5/15 on the Temporary Care Plan documented a [REDACTED] pressure sore on right heel.</p> <p>The NPN on 11/5/15 described the wound as red and warm. The note also documents Resident #100 stated the wound " ... hurts sometimes ..."</p> <p>Review of documentation of the pressure sore after 11/5/15 revealed the small open area with a partial scab had developed into a wound slightly larger than a quarter on the [REDACTED] heel.</p> <p>In interview on 2/2/16 at 11:53 a.m., when asked regarding expectation for wound assessment and monitoring, Staff B said weekly checks should be done, but in this case they should have been assessed more often.</p> <p>Other than the initial nursing assessment, no further record was found of weekly or more frequent assessment and documentation of Resident #100 [REDACTED] heel until the [REDACTED] pressure sore was found on 11/5/15, [REDACTED] days after admission.</p>	F 314			

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

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F 314	Continued From page 32 Resident #100's [REDACTED] heel wound not being routinely assessed, potentially contributed to his report of discomfort in that area. The resident's diagnosis and medical history identified wound healing as an area of concern. The absence of consistent thorough skin assessment and wound prevention measures predisposed the resident to unidentified discomfort, potential unidentified worsening of the wound.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation interview and record review, the facility did not consistently address all factors that may have been precipitating causes for each fall for 1 of 3 residents (#55) reviewed for accidents. In addition, the facility failed to ensure safety measures related to choking risks for the resident. Failure to attempt to identify a time pattern, assessing possible causes, developing new interventions and strategies and reevaluating for effectiveness, and following own plan of care to attempt to prevent further falls, resulted in recurrent falls with potential for serious injury. Failure to ensure safety measure were in	F 323	F323 Resident #55 is no longer residing in the facility. All residents with falls will have precipitating causes addressed for each fall and reviewed to reduce and/or prevent further accidents. Falls will continue to be reviewed in a interdisciplinary (IDT) meeting to develop a comprehensive/interdisciplinary approach to prevent to the prevention of accidents. Residents will continue to be supervised in the dining rooms. Nursing staff will receive training regarding positioning residents to	3/16/16

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	<p>Continued From page 33</p> <p>place to prevent choking may have contributed to an upper respiratory infection and death.</p> <ol style="list-style-type: none"> 1. Refer to F248 for facility failure to provide meaningful activities. 2. Refer to F250 for facility failure to involve Social Services. 3. Refer to F329 to facility failure to assess and monitor target behaviors to determine effectiveness of psychotropic medications <p>HISTORY Record review of Resident #55 ' s 4/17/15 Minimum Data Set (MDS), an assessment tool, revealed the resident was admitted on [REDACTED] 15 with diagnoses including [REDACTED]</p> <p>[REDACTED] The resident required 1 to 2 staff members for all activities of daily living (ADL ' s) and mobility. The resident presented with moderate to severe memory loss, confusion, trouble concentrating and spoke with unclear speech. The resident did not demonstrate behaviors or report pain. The resident had a mechanical diet pertaining to difficulty with swallowing and increased risk of choking. In addition, the resident was identified as a fall risk, experienced recurrent falls, and staff anticipated his needs. Medications included a mood stabilizer, two antidepressants, a sedative and an antianxiety.</p> <p>Resident #55 was not on a scheduled pain medication regime. No non-medical interventions were in place.</p> <p>ACCIDENTS</p>	F 323	<p>F323 continued</p> <p>decrease risk of aspiration and/or choking. Nursing staff will also be re-in-serviced regarding the Accident/Incident Investigation Process. Training will include identifying a time pattern, assessing for possible causes, developing interventions and evaluating for effectiveness.</p> <p>Random rounds will be done in the dining rooms with focus on resident positioning.</p> <p>Findings will be presented to the quality assurance committee with recommendations as appropriate.</p> <p>Director of Nursing and/or designee will monitor for compliance.</p>	

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

PRINTED: 02/12/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505473	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2016
NAME OF PROVIDER OR SUPPLIER UNIVERSITY PLACE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5520 BRIDGEPORT WAY WEST UNIVERSITY PLACE, WA 98467		
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F 323	<p>Continued From page 34</p> <p>According to the Incident and Accident Log, Resident #55 experienced 26 falls between 7/13/15 and 12/21/15. 23 of the falls were unwitnessed, 16 falls occurred while in the wheelchair, 10 occurred out of bed. Record review of incident reports and staff interviews, the facility did not identify the root cause of the falls. There was no evidence of an analysis of times of day, correlation of the falls that occurred to identify if the falls may have anticipated his/her needs, to include wanting to go to bed, get out of bed, hunger or thirst, toileting needs, medication changes or side effects, and boredom.</p> <p>Review of the Fall Risk Evaluation dated 7/26/15 revealed the initial evaluation was incomplete and undated. Two subsequent evaluations were undated, but revealed a score of 20 which identified Resident #55 as a high fall risk due to medications used, health conditions, balance, mobility, and continence issues, cognitive and behavioral symptoms (to include confusion, disorganized speech, restlessness, lethargy, abusive and resists care) and history of falls.</p> <p>Record review of the care plan 11/17/15 revealed Resident #55 was identified as a fall risk to include confusion, deconditioning, psychoactive drug use, gait/balance problems and refusals to have wheelchair leg rests in place. Interventions identified included:</p> <ul style="list-style-type: none"> -Staff were to anticipate and meet the resident's needs initiated 4/23/15 -Staff were to ensure the call light was within reach 4/23/15 -Frequent safety reminders (asking for assistance, remind to sit up in wheelchair) initiated on 7/13/15 	F 323			

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

PRINTED: 02/12/2016
FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 35</p> <ul style="list-style-type: none"> -Use tilt and space wheelchair for positioning initiated 7/28/15 -Dysom (a rubber mat) under the wheelchair cushion to prevent sliding initiated 7/29/15 -Keep the resident in line of sight initiated 8/12/15 -Staff were not leave the resident in his/her wheelchair unattended in his/her room 8/18/15 -Low bed, second mattress to floor 8/27/15 -Puzzle mat to floor 9/3/15 -Priority lay down after meals initiated 11/10/15. <p>No additional interventions were initiated after 11/10/15.</p> <p>Record review and interview revealed no evidence of the general patterns or the root cause of the falls were identified.</p> <p>According to the incident reports for 7/13/15 at 9:00 a.m., 8/1/15 at 5:45 p.m., 8/18/15 at 7:30 a.m., 2:05 p.m., 9/2/15 at 8:00 a.m., and 11/10/15 at 1:45 p.m., Resident #55 reported s/he wanted to go to bed or get out of bed when interviewed. There was no evidence that the facility attempted to identify the resident's sleep pattern or routine, ability to tolerate sitting in a chair for a period of time, was attempting to communicate discomfort or another need.</p> <p>The resident reported s/he needed to go to the bathroom when interviewed why s/he fell on 7/28/15. There was no evidence that the facility evaluated the need or attempted a toileting program.</p> <p>The resident reported s/he wanted to leave the facility, to "go home" or "get out of here," prior to the fall on 8/26/15 at 6:30 p.m., 11/3/15 at 1:20 p.m., and 11/4/15 at 2:05 p.m. It was not clear if</p>	F 323		

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

PRINTED: 02/12/2016
FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 36</p> <p>the resident wanted to get out of the wheelchair or go home.</p> <p>Statements made by the resident at the time of the falls on 7/14/15 (both falls), 8/9/15, 8/18/15, and 9/2/15, included "I wanted to go to the kitchen," "I wanted to go to the garage," "I wanted to find my taxes," and "I wanted to rearrange my room." There was no evidence the resident was assessed to identify if additional needs were not being met, such as hunger or boredom.</p> <p>Unknown circumstances resulted falls on 7/24/15, 7/26/15, 8/10/15 at 7:30 p.m., 8/16/15, 9/1/15, 9/18/15, 9/22/15, 10/6/15, 10/15/15, and 12/21/15. The facility did not evaluate or assess the potential reasons or root cause why the resident may have fallen or what the resident was attempting to do at the time to identify potential needs not being met. The care plan stated the staff were to anticipate the resident's needs and attempt to determine the cause of the falls. The facility did not follow the plan of care.</p> <p>Adequate supervision was not provided to Resident #55. Record review of care plan dated 8/12/15 revealed the resident was to be in line of sight and not to be unattended in his/her room while in the wheelchair. Twenty-three of the falls were unwitnessed that occurred at the nurses' station, the hallway or the resident's room after s/he propelled him/herself to the room. Sixteen falls occurred after the intervention was put in place. The facility did not follow the plan of care.</p> <p>Witness statements included in the incident reports described the resident to "slide" out of the wheelchair onto the floor (11/4/15). Review of</p>	F 323			

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

PRINTED: 02/12/2016
FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 37</p> <p>the August 2015 interventions revealed a tilt and space wheelchair and dysom was put in place to prevent the resident from sliding out the chair. An additional interview by Staff B revealed the Resident at times "threw" him/herself out of the wheelchair. There was no evidence that the facility assessed the falls as a potential behavior to communicate needs potentially not being met.</p> <p>In interview on 1/28/16 at 1:14 p.m., Staff B stated Resident #55 was to remain in line of sight. However the resident would self-propel his/her wheelchair and moved out of line of sight on occasion. In addition, Staff B said when investigating a fall, time of falls, toileting, consistencies, fluids offered, restlessness and pain were reviewed to identify what could have prevented the fall. Everything was in place for Resident #55 and couldn't think of any other interventions for him/her; we tried to just avoid injuries instead. Staff anticipated the resident's needs.</p> <p>FALLS RELATED TO POSSIBLE PAIN Record review and interview revealed there was no evidence that pain was consistently or accurately assessed. The form titled "Pain Evaluation" dated 4/10/15 at 3:00 p.m. revealed the resident verbally denied pain, was at risk for pain and experienced pain in the past. The licensed nurse indicated that the resident was not cognitively impaired or had communication difficulties, despite diagnoses, evidence of memory loss and delusions. The pain evaluation was incomplete to include the Abbey Pain Scale (a non-verbal measurement of pain in people with dementia), past pain intervention, activities that pain has interfered with and effectiveness of interventions attempted.</p>	F 323			

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

PRINTED: 02/12/2016
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OMB NO. 0938-0391

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F 323	Continued From page 38 Subsequent evaluations performed on 7/16/15 and 7/24/15 determined the resident denied pain and did not exhibit signs or symptoms. The Abbey Pain Scale was scored a zero, for no vocalizations, facial expressions, behavioral changes, physiological changes or physical changes had occurred with Resident #55 that could potentially be identifying signs and symptoms of pain. Record review of the MAR for November 2015, December 2015 and January 2016, pain was to be monitored every 4 hours while awake using a number or verbal scale. If the resident was unable to respond, clinical signs were to be assessed for pain, including crying restlessness, care refusals, facial expressions. Pain was not identified for Resident #55 each month on a daily basis, as evidence by a documented "zero." Nursing progress notes and incident reports dated 7/13/15, 7/14/15, 7/22/15, 8/18/15, 11/3/15, 11/4/15, 12/14/15, 12/15/15, 12/16/15, 12/17/15, 12/19/17, 12/20/15, 12/21/15, 12/22/15, 12/23/15, 12/24/15, 12/26/15, 12/28/15, 1/1/16, and 1/2/16, documented Resident #55 demonstrated some or all of the clinical signs of pain. In interview on 1/21/16 at 9:40 a.m., Staff BB stated Resident #55 was normally "very wiggly, even in the tilt and space wheelchair." According to Staff BB, Resident #55 fell on 12/21/15 after staff reminded the resident five times to reposition himself while sitting in his wheelchair. Although the resident had significant short term memory loss and required more and more physical assistance from staff to reposition, staff continued to remind the resident to reposition himself according to Staff BB and progress notes	F 323			

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

PRINTED: 02/12/2016
FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 39 dated 12/21/15.</p> <p>In interview on 1/28/16 at 11:54 a.m., Staff M stated non-verbal signs and symptoms of pain in a resident with dementia include facial grimacing, moaning, movement of extremities, crying out, restlessness and agitation. As these behaviors occurred, staff were to look for interventions like taking them for a walk if s/he was sitting in the chair too long, given them a magazine to read or medication. For residents that exhibit behaviors or falls repeatedly, finding effective interventions may be ongoing.</p> <p>Record review and interview revealed there was no evidence of interdisciplinary team involvement to evaluate the root cause or the needs of the resident. There was no evidence to support a multidisciplinary approach as to why Resident #55 fell, the impact of the resident's cognitive, mood, behavioral, physical and medical status on the resident's ability to communicate needs effectively.</p> <p>There was no evidence of the evaluation of the impact of staff interventions with social services or activity participation to include medication regime and side effects, preferred routine, personality traits, preference sans meaningful activities that may have prevented future falls an improved quality of life.</p> <p>Review of the Mental Health Evaluation dated 7/22/15, revealed the resident exhibited episodes of agitation, throwing things, cursing at staff, uncooperative, confused, depressed with crying spells, and easily angered. The evaluation included input from the POA, who reported a decline in the resident's function, memory, word</p>	F 323			

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

PRINTED: 02/12/2016
FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 40</p> <p>finding, poor sleep and paranoia. Insight and judgment was impaired. Interventions included medication changes and to continue to follow "fall protocol." There were no individualized interventions to address the resident's pain management or psychosocial needs or</p> <p>In interview on 1/28/16 at 11:28 a.m., the POA stated the resident had [REDACTED] for many years and always had lower back problems and believed s/he was in pain. The POA believed the falls were a behavior and attention seeking, which was rewarded each time the behavior was exhibited. The last three months s/he has not been able to push him/herself up in the chair or following directions, required more assistance from staff for cuing, positioning and supervision.</p> <p>In interview on 1/28/16 at 1:14 p.m., Staff B was not sure the Activity Department or Social Services was involved in the falls, for it was not mentioned in the incident reports.</p> <p>The facility failed to develop and maintain an effective process to ensure the resident environment remains free from accident hazards as possible and provide adequate supervision and assistance to prevent avoidable accidents.</p> <p>CHOKING HAZARD Observation in the North Dining Room on 1/20/16 at 12:30 p.m., Resident #55 was sitting at the Progressive Self-Feeding Program (PSFP) table next to Staff R. The PSFP table was located in a dining room that included four additional tables of residents that also required assistance to eat. Resident #55 was slouched in his/her chair and had just been served lunch, attempting to feed</p>	F 323			

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

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FORM APPROVED
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F 323	<p>Continued From page 41</p> <p>him/herself. At 12:38 p.m., the resident started coughing after taking a drink. Staff R did not intervene. 12:51 p.m., Resident #55 began coughing again, still tilted back and slouched in his/her wheelchair. 12:56 p.m., the resident had continued coughing and clearing his/her throat. Staff R did not intervene. At 12:58 p.m., Staff C and Staff T who had been assisting other residents, came over to Resident #55 and repositioned him/her in the wheelchair and the first time someone asked if s/he was okay.</p> <p>Review care plan dated 4/23/15, identified the resident as having [REDACTED] and being an aspiration risk. The resident was to sit in an upright position, eat slowly, and to be monitored for choking, coughing, refusing to eat and appearing concerned during meals.</p> <p>Record review of progress notes dated 1/23/16 revealed Resident #55 had developed chest congestion and increased lethargy. Notes dated 1/24/16, 1/25/16 and 1/26/16, reported the resident was unable to swallow, coughing and spitting out medication, refusing food and developed a fever. A speech screen was performed on 1/25/16 and diet was downgraded to puree. In addition, a care conference was held and agreed to make a Hospice referral.</p> <p>The resident passed away on [REDACTED] 16.</p> <p>In interview on 1/28/16 at 11:28 a.m., the POA stated Resident #55 had a swallowing problem and coughed when eating solid foods since s/he first arrived at the facility. Speech therapy had been working with him since he was admitted. He slouched in his chair which caused the coughing when s/he ate.</p>	F 323			

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

PRINTED: 02/12/2016
FORM APPROVED
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F 323	Continued From page 42 In interview on 1/29/16 at 12:30 p.m., Staff R reported possible signs of aspiration or choking when seeing a resident eating or drinking too fast or taking in large amounts, resulting in coughing, staff would cue the resident to slow down, take small sips or bites. Staff would look at positioning of the resident in the wheelchair. When asked specifically about Resident #55, Staff R stated s/he was seated at the PSFP table for supervision, to make him/her safer. The resident had been coughing this last month at meals, but had signed a waiver to eat regular textured foods. In interview on 1/29/16 at 1:15 p.m., Staff CC said s/he had not worked with Resident #55 since November 2015 and noticed a significant decline the day the resident was seen. The resident was cognitively impaired, required cuing from staff to sit up, eat and drink slowly and take small bites and sips. The resident had been in PSFP since admission. When asked if Staff CC was aware of the waiver the POA signed on 1/14/16 for Resident #55 to have thin liquids instead of the recommended thickened liquids, Staff CC stated "No." However, Staff CC said s/he had participated in similar waivers signed by the POA in the past. The facility failed to ensure the resident environment remained free from accident hazards as possible and provide adequate and timely intervention, supervision and assistance to prevent choking.	F 323			
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION	F 327			

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

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F 327	Continued From page 43 The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure accurate monitoring of intake and output for 2 of 2 residents (#245 and #84) reviewed for hydration. This failure placed the residents at risk for unmet hydration needs and complications related to fluid imbalance. Findings include: RESIDENT #245 Review of Resident #245's Minimum Data Sheet (MDS), a nursing assessment tool, dated 1/18/16, revealed the resident was admitted to the facility on [REDACTED] 16 with diagnoses to include [REDACTED] The 1/12/16 physician's order (PO) and dietary order (DO) indicated Resident #245 was restricted to 1500 cubic centimeter (cc) (a fluid measurement) fluids per day. The resident was to receive 750cc fluids during meals and 750cc fluids throughout the day from nursing staff. In addition, the PO included medications to increase urine output (diuretics) and [REDACTED] given for [REDACTED] which also increased output	F 327	F327 Resident #245 no longer resides in the facility. Resident #84 as well as all residents who are at risk for fluid imbalance will continue to have their intake and output monitored accuracy. The Intake and Output (I & O) policy and procedure have been reviewed and updated to include daily monitoring of I and O. All Nurse Managers have been in-serviced on the I and O policy and procedures. Random audits for completion and accuracy of I and O records will be completed for on-going monitoring. Results of the audits will be reviewed by the quality assurance committee for further recommendations. Director of Nursing or designee will monitor for compliance.	3/14/16	

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

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F 327	<p>Continued From page 44 (increase in bowel movements).</p> <p>In an interview on 1/27/16 at 11:39 a.m., Staff V stated the amount of fluid restriction was written out in the medication administration record (MAR) for nursing to know how much fluid was given each shift and how much fluid was provided by dietary during meals. S/he explained, nurses initialed the MAR indicating the resident had received the total amount of fluids expected for the shift.</p> <p>Review of the January 2016 MAR revealed fluid restriction was written as follows: 1500cc fluid restriction: dietary 750cc; nursing 750cc=day shift 350cc, evening shift 200cc, and night shift 100cc. Between 1/12 and 1/27, the nurses initialed 44 of 47 shifts.</p> <p>The January 2016 intake and output record revealed the following: Between 1/12 and 1/27, oral intake and urine output were documented for 6 of 47 shifts (on 1/12 evening shift, 1/13 evening shift, 1/14 day shift, 1/17 day shift, 1/25 day shift, 1/26 night shift). There was no documentation of bowel movements in any shift between 1/12 and 1/27. The fluid intake in the MAR was not reflected in the intake and output record.</p> <p>Review of the January 2016 meal monitor log revealed breakfast fluid intake was documented for 15 of 16 days, lunch fluid intake was documented for 14 of 16 days, and supper fluid intake was documented for 13 of 16 days.</p> <p>On 1/27/16 at 11:49 a.m., upon observation in resident #245's room, lunch tray was noted with a small glass of cranberry juice. Resident #245 had a pitcher full of water at the bedside table.</p>	F 327			

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

PRINTED: 02/12/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505473	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2016
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F 327	<p>Continued From page 45</p> <p>Record review of the facility's Intake and Output Guideline and Procedure updated 8/7/15, revealed the purpose of the intake and output monitoring procedure was to accurately determine the amount of liquids a resident has consumed and excreted in a 24-hour period. The procedure applied to newly admitted resident for the first 72 hours; residents identified via staff with the physician's input with a significant risk for subsequent fluid and electrolyte imbalance; and residents on a physician ordered fluid restriction or fluid reduction program.</p> <p>In an interview on 1/28/16 at 10:44 a.m., Staff W stated the nurses documented in the MAR if a resident was on fluid restriction. At the end of the shift the nurses were responsible for documenting the total intake and output (I & O) in the I & O record. Staff W further stated if a resident was on intake and output monitoring, the nursing aides documented the amount of fluids taken during meals in the meal monitoring log. Both nurses and nursing aides were responsible in writing down the intake and output in the intake and output sheet placed in the resident's room.</p> <p>During an interview on 1/28/16 at 12:37 p.m., Staff B explained that the nursing aides documented the intake and output on the intake and output worksheet. Nurses were expected to document the total intake and output for the shift in the intake and output record.</p> <p>The facility did not accurately monitor the intake and output of Resident #245 and did not properly implement fluid restriction ordered in the PO or DO.</p>	F 327			

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

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F 327	<p>Continued From page 46</p> <p>RESIDENT #84 Resident # 84 was admitted to the facility [REDACTED] 2014 with multiple medical diagnoses to include [REDACTED]</p> <p>Physician ordered fluid restriction of 1200 ml (milliliter) per day, dated 12/10/15 was found, to decrease potential for fluid retention. Resident #84 had been hospitalized [REDACTED] 15 - [REDACTED] 15.</p> <p>In interview on 1/26/16 at 2:02 p.m. Staff F stated Resident # 84 was on a 1200 cc (cubic centimeters) fluid restriction due to his [REDACTED]. The amounts were mapped out on the Medication Administration Record (MAR) for nursing to know how much they were to give per shift and how much Dietary would give with meals. The care directive in the resident's closet detailed this information for the Nursing Assistants.</p> <p>Review of the Intake and Output (I&O) monitor sheets revealed the following: on 12/1 - 12/7 intake was documented for 9 of 18 shifts, on 11/22 - 11/28 intake was documented for 5 of 21 shifts, on 11/15 - 11/21 intake was documented for 3 of 21 shifts, and on 11/8 - 11/14 intake was documented for 5 of 21 shifts. No I&O sheets were recorded past 12/7.</p> <p>Review of January 2016 meal monitor, completed 1/27/16, indicated breakfast fluid intake was not documented for 1 of 26 days, lunch fluid intake was not documented for 2 of 26 days and dinner fluid intake was not documented for 22 of 26 days.</p> <p>In interview on 01/27/2016 at 10:10 a.m. Staff G stated Resident #84 was not monitored for fluid</p>	F 327			

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

PRINTED: 02/12/2016
FORM APPROVED
OMB NO. 0938-0391

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F 327	Continued From page 47 intake because s/he was non-compliant. S/he said for other residents that were monitored it was in the MAR how much the restriction was and how much nursing gave. Staff G explained an initial in the box on the MAR acknowledged a fluid restriction was in place. At the end of each shift, Staff G said, nursing entered how much fluid was consumed from the meal monitor in addition to what nursing had given for the shift. However, in interview on 01/28/16 at 10:50 a.m. Staff F said "there should have been something on the MAR to document how much fluids were taken in by a resident on fluid restrictions each shift." Staff F stated "Resident #84 does not have one", confirming monitoring was not in place. S/he further stated "When readmitted from hospital it didn't transfer over, it's my fault, it was something that was overlooked." Review of the MAR for December 2015 revealed typed instructions for fluid restrictions of 1.2 liters per day: 800 ml to dietary, 400 ml to nursing for Resident #84. The January 2016 MAR, however, did not have any documentation of fluid restriction monitoring until brought to the attention of the facility. The facility did not accurately monitor intake and output of Resident #84 who had a high risk for fluid and electrolyte imbalance.	F 327			
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including	F 329	F329 Resident #55 no longer resides at the facility.	3/16/16	

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

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F 329	<p>Continued From page 48</p> <p>duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure there was adequate indication for administering a psychoactive medication, consistent monitoring of behaviors and side effects, and non-medical interventions put in place prior to starting a psychoactive medication and for 3 of 5 Sampled Residents reviewed for unnecessary medications (#s 55, 60, 81). These failures placed the resident at risk for undetermined efficacy and adverse side effects related to the medication.</p> <p>Findings include:</p>	F 329	<p>F329 continued</p> <p>All residents in need of behavior monitoring and Resident #60 continues to be monitored for behaviors and adverse side effects of medication. The care plan and behavior monitoring record for Resident #81 were updated to reflect the correct medications and established behavior monitoring. The Psychoactive Monitoring Committee reviewed the residents' medications and behavior monitoring on 2//8/16.</p> <p>Residents not receiving psychoactive medication but exhibiting behaviors will have behaviors monitored with interventions to manage behaviors.</p> <p>Residents with behavior monitoring will be reviewed by the Behavior & Psychoactive Monitoring Committee to establish a plan to stabilize behaviors.</p>	

DM
3/2/16

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F 329	<p>Continued From page 49</p> <p>RESIDENT #55 Record review of Resident #55's 4/17/15 Minimum Data Set (MDS), an assessment tool, revealed the resident was [redacted] years old, admitted on [redacted] 15 with diagnoses including [redacted].</p> <p>[redacted] The resident required 1 to 2 staff members for all activities of daily living and mobility, presented with moderate to severe memory loss and disorientation, trouble concentrating and spoke with unclear speech. The resident did not demonstrate behaviors or report pain. The resident was identified as a fall risk and staff were to anticipate his/her needs.</p> <p>Record review of the Medication Administration Record (MAR) dated January 2016 revealed two routine medications for constipation, [redacted] (a mood stabilizer) for behaviors, [redacted] (an antibiotic) for [redacted] (antidepressant) routine and as needed for sleeplessness related to [redacted] (antidepressant) for increased confusion, [redacted] as needed for increased [redacted]. The orders for [redacted] and [redacted] directed licensed staff to "observe the patient closely for significant side effects."</p> <p>Record review of the care plan dated 12/4/15 identified Resident #55 as having impaired cognitive function [redacted] short and long term memory loss, behaviors such as yelling, restlessness, and refusals. The resident was prescribed several psychotropic (mood and behavior altering medication) medications to include and antidepressant, antianxiety, sedative/hypnotic. Interventions included administering medications as ordered, monitor and document for side effects and effectiveness</p>	F 329	<p>Social Services and nursing staff have been in-serviced on behavior monitoring.</p> <p>Random audits will be completed on behavior monitoring and reported to the quality assurance committee for further review.</p> <p>Director of Nursing and Social Service Director will monitor for compliance.</p>	

PM
3/2/16

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

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F 329	<p>Continued From page 50 every shift.</p> <p>Review of physician's orders revealed [REDACTED] was discontinued 7/20/15, [REDACTED] started 7/22/15, [REDACTED] started 12/3/15 three times a day as needed for increased anxiety [REDACTED] was started 12/7/15 for behaviors, [REDACTED] was increased on 12/10/15 for increased confusion, [REDACTED] increased 12/24/15 for behaviors. An order was written to monitor orthostatic blood pressures on the tenth of every month for the use of the psychotropic medications.</p> <p>Record review of document titled "Behavior monthly flow sheets" dated November 2015, December 2015 and January 2015 revealed target behaviors as tearfulness, verbalizing feelings of [REDACTED] and slept less than six hours on night shift.</p> <p>For the month of November 2015, two episodes of tearfulness were observed on 11/17/15 and 11/19/15 on evening shift, with non-medical intervention of redirection was used and was effective. Eleven episodes were documented on 12/25/15 on day shift, with medication given twice as an intervention. No non-medical interventions were attempted and effectiveness was not documented. A "zero" was documented for episodes on 12/3/15 and 12/12/15 on day shift. All other days and shifts were blank. There was no sleep monitor to monitor sleep patterns and hours of sleep.</p> <p>Behavior flow sheet for December 2015 revealed</p>	F 329		

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

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FORM APPROVED
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F 329	<p>Continued From page 51</p> <p>11 episodes of tearfulness on evening shift of 12/7/15 with no interventions, outcome or effectiveness documented. Resident #55 was observed to have had 11 episodes of tearfulness on 12/7/15 (Pearl Harbor Day) evening shift with no interventions, outcome our effectiveness documented. A zero was documented for number of episodes on 12/3/15 and 12/12/15 on day shift. The resident was observed to have been tearful 11 times on day shift 12/25/15 (Christmas Day), with medication documented as the intervention. Effectiveness of the intervention was not documented. Zero episodes were documented on night shift for 12/6/15 and 12/7/15. A zero was documented for expressing no appetite for 5 days (two on day shift, one on evening shift and two on night shift). Resident #55 denied feelings of [REDACTED] on evening shift 12/3/15 and night shift 12/4/15, 12/5/15, and 12/6/15. All other days and shifts were blank. There was no sleep monitor in place to identify sleep patterns and document hours of sleep.</p> <p>Record review of the MAR's revealed orthostatic blood pressures were not performed for the months of November 2015 and December 2015, as indicated for adequate monitoring of side effects of psychotropic medications.</p> <p>Progress notes for November 2015 and December 2015 revealed inconsistent documentation when charting on behaviors. In addition, not all target behaviors were identified in the progress notes.</p> <p>In interview on 1/28/15 at 3:30 p.m., Staff F</p>	F 329			

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

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FORM APPROVED
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F 329	<p>Continued From page 52</p> <p>stated his/her expectation was to chart behaviors daily on the behavior monitor. This facility has gone back and forth this last year how to document, whether by exception or daily. Staff chart by exception. "There should not be any zeros documented. I have not seen any policy how to document." When a resident exhibited a change in behaviors, the doctor would be contacted, resulting most likely a mental health evaluation. Depending on the situation, Social Services may get involved.</p> <p>In interview on 1/26/15 at 11:15 a.m., Staff B reported behavior monitor sheets and progress notes are used in the psychotropic meetings to determine if behaviors were occurring. Staff was to document "out of the ordinary behaviors" and specific target behaviors ongoing. When referred to Resident #55's behavior monitor for December 2015, Staff B stated that staff documented by exception. In addition, Staff B stated s/he had a conversation with staff to document everything staff was seeing. If the behavior was ongoing, a progress note should be initiated. Staff B stated the [REDACTED] that was started in December 2015 was for the resident perseverating on ideas or delusions. Perseverating was not a target behavior listed on the behavior monitor.</p> <p>Staff A provided the documented in-service for behavior sheets, dated 5/19/15. It was presented by Staff F and a social worker. Instructions included when a behavior was observed, the licensed nurse was to indicate the number of times the target behavior was seen, interventions attempted, and if the interventions were effective or not. The documentation was imperative for the</p>	F 329			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 329	<p>Continued From page 53</p> <p>residents' mental health and was "not optional."</p> <p>Review of facility policy titled, "Behavior Assessment and Monitoring" dated April 2007 revealed the Assessment Policy included nursing staff identifying, documenting onset, duration and frequency of problematic behaviors or changes in behavior in cognition or mood and any precipitating or relevant factors and outcomes associated with interventions. Interventions were to include situations where nonpharmacological approaches were indicated and would institute such measures to the extent possible. The psychoactive medications would be monitored for side effects.</p> <p>The facility failed to ensure a functional system was in place to consistently monitor frequency of behaviors, precipitating factors, ensuring non-pharmacological intervention were attempted prior to administering medication, and response to interventions in attempt to identify effectiveness per facility policy and federal regulations.</p> <p>RESIDENT #60 According to the 2008 Mosby's Nursing Drug Reference, psychotropic medications including antidepressants, antipsychotics and antianxiety medications may have adverse side effects to include changes in sleep pattern, drowsiness, blurred vision, hallucinations, agitation and/or weight loss.</p> <p>Record review of 10/31/15 MDS revealed Resident #60 was admitted [REDACTED] 14 with</p>	F 329			

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

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FORM APPROVED
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F 329	<p>Continued From page 54</p> <p>diagnoses including [REDACTED]. The resident was alert and oriented to person and place, and had mild short term memory loss. Medications included and [REDACTED]. The resident required two staff for assistance with all activities of daily living and mobility. Vision was impaired even with corrective lenses. The resident reported double vision. No resistive behaviors, delusions or hallucinations exhibited.</p> <p>Observation on 1/20/16 at 3:29 p.m., 1/21/16 10:29 a.m., 1/21/16 at 2:13 p.m., 1/22/16 at 10:35 a.m., and 1:45 p.m., 1/25/16 at 11:15 a.m. and 2:15 p.m., 1/26/15 at 11:55 p.m. and 4:17 p.m. resident was sleeping in bed with television on and not easily aroused.</p> <p>The resident was unavailable for an interview due to being asleep multiple times throughout the day, multiple days. The resident triggered for being potentially overly sedated because of the various times and days observed, the resident was sleeping soundly, not seen in activities or socializing with other residents.</p> <p>Record review of mental health evaluation dated 6/3/15 revealed reports of increased hallucinations and/or delusions. In result, the physician increased the [REDACTED].</p> <p>Record review of mental health evaluation dated 8/19/15 revealed reports of confusion, refusing care, increased hallucinations, depressed mood and "feels lonely." Recommendations to increase the [REDACTED] medication to three times a day.</p>	F 329			

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

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F 329	Continued From page 55 Record review of the September 2015 MAR revealed the resident received an order to start a second [REDACTED] and poor appetite. Record review of the document titled "Behavior Monitor Flow Sheets" for June 2015 through January 2016 revealed target behaviors were reports from the resident seeing/hearing people who aren't actually present, increased agitation as evidenced by escalation of tone of voice, eats less than 75% of meals, statements of feeling sad/down/depressed, and teary episodes. Each month's behavior monitor revealed lack of monitoring frequency, interventions attempted, effectiveness of interventions for each behavior exhibited. No sleep monitor was in place to identify or trend sleep patterns or hours of sleep. Nursing progress notes from August 2015 through 1/27/16 did not consistently document all target behaviors, interventions and effectiveness on a daily basis. Review of documentation of Resident's weights reveal weight loss of 14% over a 7 month period. The resident was [REDACTED] pounds on 7/2/15 and [REDACTED] pounds on 1/1/16. According to the behavior monitors, the resident did not exhibit the behavior of eating less than 75% of his/her meal. In interview on 1/26/16 at 4:45 p.m., Resident #60's roommate stated that Resident #60 is hardly up. When s/he is, s/he talked a lot and would wear him/herself out. When asked the best time to talk with Resident #60, the roommate	F 329			

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

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FORM APPROVED
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(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 329	<p>Continued From page 56</p> <p>stated s/he was not certain. Staff "snatch" him/her up in the morning and go tired later. The resident did not get up as much as s/he used to.</p> <p>In interview on 1/26/16 at 5:04 p.m., Resident #60 was sitting up in the wheelchair in the hallway. The resident reported that s/he has been sleeping a lot because s/he has been tired. The resident pulled back his/her shirt collar and pointed out how s/he has lost weight. When asked if s/he had trouble falling asleep or staying asleep, the resident reported sleeping well because s/he must have been sleeping. Resident #60 stated s/he attends activities when s/he was not sleeping.</p> <p>In interview on 1/29/16, it was reported Resident #60 has been observed sleeping several hours of the day other than meal time, throughout the survey period. Staff B stated the sleeping pattern did not sound like Resident #60, that s/he usually participates in activities, like manicures. Resident #60 was observed to have chipped nail polish and long nails.</p> <p>The facility failed to adequately monitor target behaviors exhibited, frequency, nonmedical interventions attempted, effectiveness of interventions prior to administering a medication and potential adverse side effects of current medications.</p> <p>Resident #81 According to the admission record updated 1/14/16, Resident #81 was admitted to the facility on [REDACTED] 15 with multiple diagnoses to include [REDACTED]</p>	F 329			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 329	<p>Continued From page 57</p> <p>[REDACTED]</p> <p>Review of Minimum Data Sheet (MDS), a required assessment tool, dated 12/6/15 revealed moderate cognitive impairment. Under mood assessment, it was indicated resident felt tired or had little energy and had trouble concentrating. No behavioral issues were identified. The use of [REDACTED] medications were noted.</p> <p>The physician order (PO) dated 11/23/15 revealed Resident #81 was ordered for [REDACTED] (antianxiety) and [REDACTED] (antidepressant) medication.</p> <p>According to the facility's behavior assessment and monitoring policy and procedure revised April 2007, nursing staff were to obtain and document ongoing reassessments of changes in behavior, mood and function. Nursing staff and the physician were expected to document (either in the progress notes, behavioral assessment form, or other comparable approaches) the number and frequency of episodes; preceding or precipitating factors; interventions attempted; and outcomes associated with interventions to specific problem behaviors. Nursing staff and the physician were directed to periodically reconsider the indication for psychoactive medication.</p> <p>Review of the behavior monthly flow sheet for December 2015 and January 2016 revealed target behaviors to include tearfulness, verbalization of thoughts or feelings of [REDACTED] increased agitation and statements of [REDACTED]</p> <p>In the December 2015 behavior flow sheets, a</p>	F 329			

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F 329	<p>Continued From page 58</p> <p>zero was documented on 12/28 day shift for episodes of the target behaviors. Ninty-two of ninty-three shifts were not documented. Behavior flow sheets for January 2016 revealed a zero was documented for episodes of agitation and statements of anxiety on 1/26 and 1/28 day shift and zero episodes of tearfulness and verbalizations of [REDACTED] on 1/28. Twenty-six of twenty-eight shifts were not charted. No documentation on interventions used, outcome, and side effects were noted in both the December and January behavior flow sheets.</p> <p>Review of the the nursing progress notes between 11/23/16 and 1/27/16 revealed staff did not consistently monitor target behaviors for Resident#81 on an ongoing basis.</p> <p>During an interview on 1/26/16 12:53 p.m., Staff T said nurses charted in the behavior monitoring sheet by exception. S/he further stated "only when residents were manifesting or showing any change in behavior, nurses charted in the behavior flow sheet."</p> <p>In an interview on 1/27/16 at 1:27 p.m., Staff M stated "it depends on the nurse, some chart by exception and others chart every shift."</p> <p>On 1/28/2016 2:52 p.m., upon interview, Staff AA was asked how behavior was being monitored. S/he stated behavior monitoring was charted by exception. According to Staff AA, "We used to put zeros before in the behavior monitoring sheet but we were told to just chart by exception." Staff AA said, behavior was documented in the blue behavior monitoring sheet only if resident was seen exhibiting any behavior. S/he stated, alert charting was done for those who were monitored</p>	F 329			

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F 329	Continued From page 59 for psychosocial harm and behavioral changes. Staff AA said the medical doctor (MD) was notified if resident needed any mental health evaluation. The facility did not provide consistent behavior monitoring for Resident #81 which placed resident at risk of using unnecessary medications.	F 329			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure staff practiced proper hand hygiene and serve food in a sanitary manner to prevent potential food borne illness exposure and cross-contamination of germs in the kitchen, dining room and while serving trays to residents in their rooms. This placed residents at risk of obtaining a food-borne illness or other infections. NORTH DINING ROOM	F 371	<u>F371</u> Staff members O, Q and P were in-serviced regarding proper hand hygiene, food handling and proper food delivery. Staff P was also rein-serviced regarding supervisory responsibilities to store, prepare, distribute, and serve food under sanitary conditions. All staff involved in food handling and meal service will be rein-serviced regarding hand hygiene, food handling and serving techniques. Dietary Supervisor will conduct sanitation audits to include food prep, food handling and serving food.	3/16/14	

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F 371	<p>Continued From page 60</p> <p>Observation on 1/20/16 between 11:40 a.m. and 11:55 a.m., two unidentified Staff members passed hot beverages and lunch trays to the 200 hall residents. Multiple surfaces were touched including lunch trays, mug handles, coffee and hot water pots handles, sugar packets, bed side tables, plate warmer lids and rims of the mugs for residents' tea, hot chocolate or coffee. No hand hygiene was observed between the multiple surfaces and tasks during this period of time.</p> <p>Observation on 1/26/16 at 5:43 p.m., Staff O assisted in the dining room. Staff O grabbed silverware, wrappers, picked up a meal tray and put it down on the table. Staff O took a drink order for a table, went to the beverage cart, made a cup of coffee for a resident, put packets of sugar in his/her pocket, carried the mug of coffee with his/her fingertips by the rim, placed the mug in front of the resident, pulled the packets of sugar from his/her pocket and placed them on the table.</p> <p>Observation on 1/26/16 at 6:19 p.m., Staff O wheeled Resident #250 to his/her room, left the resident's room, entered the hallway to the beverage cart, filled a mug of hot water, threw the tea wrapper away in the garbage, placed a bag of tea in the water, and carried the mug by the rim with his/her finger tips to Resident #250. Staff O did not demonstrate hand hygiene during the process.</p> <p>In interview on 1/26/16 at 6:22 p.m., Staff O reported hand hygiene was to be performed when you enter the dining room and when your hands are visibly soiled.</p> <p>KITCHEN Observation during tray line on 1/27/16 at 11:23</p>	F 371	<p>F371 continued</p> <p>The Dietitian will conduct random audits and observations of staff to identify and correct any issues related to food handling and meal delivery.</p> <p>The food handling audits will be reviewed by the quality assurance committee for further recommendations.</p> <p>Administrator will monitor for compliance.</p>	

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F 371	<p>Continued From page 61</p> <p>a.m., while wearing gloves, Staff Q touched a plate, plate warmer, various serving utensils, the counter, cornbread with his/her thumb, tray card, the counter. Staff Q picked up a plate and plate warmer, picked up a hamburger bun, serving utensils, lettuce with his/her finger, held the bun down with his thumb, covered the plate, placed on the counter, picked up tray card. This cycle repeated multiple times with the same pair of gloves.</p> <p>Observation at 11:32 a.m., Staff Q replaced his/her gloves, but did not wash his/her hands before putting on the clean ones.</p> <p>Observation on 1/27/15 between 11:43 a.m. and 12:08 a.m., Staff Q continued to wear the same pair of gloves and touch multiple surfaces including the counters, side of his/her apron and pants, the soup bowl tray from under the counter, the plates and warmers, a hamburger bun, the handles of scooping utensils, lettuce and tomato with tongs, and lettuce and bun without tongs. No handwashing or change of gloves had been performed.</p> <p>The manager, Staff P, supervised the tray line throughout the process, and did not say anything to Staff Q.</p> <p>In interview at 12:08 p.m., Staff P reported s/he consistently supervised tray line. Staff P stated the ready-to-serve food was supposed to be touched with clean gloves or with a barrier. At that moment in tray line, Staff Q picked up a piece of lettuce with gloved fingers, tore the large piece of lettuce in half, placed one side back in the container and the other piece on the bun. Staff P stated the lettuce should have been picked up</p>	F 371			

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F 371	Continued From page 62 with a barrier, or tongs, not fingertips. Staff P did not inform Staff Q during this observation. Staff P provided a copy of the facility policy titled, "Hand Washing," dated 2013. The procedure stated clean hands and exposed portions of arms immediately before engaging in food preparation including working with exposed food. When to wash hands included after handling human body parts other than clean hands, after handling soiled equipment or utensils, during food preparation to prevent cross contamination when changing tasks, and before donning gloves.	F 371			

Nursing Home Survey Report

STATE REQUIREMENTS

1. Page 1 of 3 Pages

2. DATES OF DATA COLLECTION

1/20/16, 1/21/16, 1/22/16, 1/25/16, 1/26/16,
1/27/16, 1/28/16, 1/29/16

5. TIME OF SURVEY

Day Night Weekend Holiday

7. LICENSE NUMBER

1098

3. NAME OF FACILITY University Place Care Center	4. TYPE OF SURVEY <input checked="" type="checkbox"/> Full <input type="checkbox"/> Post <input type="checkbox"/> Complaint <input type="checkbox"/> Other: specify _____	5. TIME OF SURVEY <input checked="" type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Weekend <input type="checkbox"/> Holiday
6. STREET ADDRESS 5520 Bridgeport Way West	CITY STATE ZIP CODE Tacoma WA 98467	7. LICENSE NUMBER 1098

NOTE: According to RCW 18.51.060, the Department is authorized to deny, suspend or revoke a license and/or assess monetary fines for deficiencies cited in this report.

8. <input checked="" type="checkbox"/> The requirements of the following Washington Administrative Code (WAC) were not met: <u>WAC 388-97-3320(1) Hot Water.</u> <input type="checkbox"/> The following deficiencies were determined to be corrected.	9. REPEAT DEFICIENCY FROM SURVEY DATED 10. NEW CITATION ON POST SURVEY <input type="checkbox"/> Yes <input type="checkbox"/> No	11. LICENSEE'S PLAN OF CORRECTION 12. LICENSEE'S PLANNED DATE OF CORRECTION <p style="text-align: right; font-size: 1.2em;">3/16/16</p> <p>As stated in the SOD, there have been several upgrades and improvements to the plumbing system in the past few months. Maintenance staff will continue to monitor for acceptable water temperature range. Maintenance will continue to monitor for compliance and make any necessary improvements and/or seek assistance to comply with this regulation. The Administrator will continue to conduct random audits of the water temperatures at different times of the day. Staff, including Maintenance personnel, have been in-service regarding the procedure if the water temperature is not within the acceptable range. The Administrator will report findings to the quality assurance committee for further review.</p>
DEFICIENCY WAC 388-97-3320 Hot water. The nursing home must ensure: (1) The hot water system maintains water temperatures at one hundred ten degrees Fahrenheit, plus or minus ten degrees Fahrenheit, at fixtures used by residents and staff. This requirement was not met as evidenced by: Based on observation, interview and record review the facility failed to ensure water temperatures were consistently within the required range in the showers and the sink and bathroom faucet in resident rooms. This failure placed residents at potential risk for skin damage resulting from a hot water burn and not having preferences met for higher temperature water. Findings include: Review of resident council minutes for the months of September and December 2015 documented reports of facility water concerns. On September 17, 2015 a resident reported only one shower stall working on 300 hallway and that shower had water temperature extremes, super hot or super cold. Residents reported in the December 16, 2015 meeting that bathroom faucet water		

pressure was high and splashed all over. Another resident reported the hot water had been staying cold and had to go to another hall totake a shower. A third resident reported water on the floor around the toilet.

Observations on 1/20/16 and 1/21/16 of water temperatures in resident rooms on the 100, 200 and 300 hallways found water temperatures in various rooms on the hallways above 120 degrees fah renheit (F).

Temperatures measured with the surveyors Comark PDT300 thermometer resulted the following:

Room 122: sink 121.7 (F); bathroom 121.8 F on 1/20/16 at 2:35 p.m.

Room 108: sink 123.7 F; bathroom 120.2 F on 1/20/16 at 2:58 p.m.

Room 421: sink 125.7 F; bathroom 124.2 F on 1/20/16 at 3:18 p.m.

Room 418: sink 125.8 F on 1/20/16 at 3:24 p.m.

Room 207: sink 121.5 F on 1/21/16 at 9:53 a.m.

Room 246: sink 122 F on 1/21/16 at 2:55 p.m.

In interview on 01/28/2016 at 1:48:11 PM, Staff Y said s/he was not aware of hot water temperature, only resident reports of cold water.

A review of the maintenance record of the Room Temperature Log for water temperatures revealed random measurements above the 120 F temperature range recorded in September 2015 on the 300 hallway and 400 hallway.

A Room Temperature Log dated 1/14/16 records water temperatures in various rooms on all four hallways, 100/200 hallway shower rooms, 300/400 hallway shower rooms and the therapy room were above 120 F degrees. Twenty-seven of the thirty-six measurements resulted temperatures in the range of 120.2 to 132 F. Water temperature measurements logged on 1/16/16 for these same areas resulted eleven of thirty-six measurements in the range of 121.2 to 125.6 F.

Review of Room Temperature Logs for the months of September recorded four water temperatures of 120.3 to 122.3 F. The month of November water temperatures were withing range but recorded "corrective action taken to adjust water temperature" on 11/25/15 - "New mixer valve system 100/200 circuit, rebuilt mixer valve system 300/400 circuit."

During the above interview, Staff Y also stated the valves on the boiler for 300/400 hallway had been replaced on Friday, 1/22/16.

Review of water temperatures measured in resident rooms on the 300 and 400 hallways dated 1/26/16 and 1/27/16 following the valve replacement revealed random low water temperature measures of 93 to 99.8 degrees throughout the day.

The water temperature issues within the facility by report has been an ongoing issues. Despite repairs and parts replacement, the issues remain unresolved and the root cause of the problem not identified placing residents at risk for exposure to unstable water temperature and possible skin damage.

13. SURVEYOR'S SIGNATURE(S)

SIGNATURE <i>Lotella Maestas</i>	DATE <i>2-12-16</i>	SIGNATURE <i>J. Edwards</i>	DATE <i>2/12/16</i>
SIGNATURE	DATE	SIGNATURE	DATE

14. LICENSEE OR AGENT

SIGNATURE OF LICENSEE (OR AGENT) <i>Pamela McDaniel</i>	TITLE <i>Administrator</i>	DATE <i>2/19/16</i>
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AGING AND DISABILITY SERVICES ADMINISTRATION
Nursing Home Survey Report
 STATE AND CORRESPONDING FEDERAL REQUIREMENTS

1. Page 1 of 1 Pages

2. DATES OF DATA COLLECTION
**1/20/16, 1/21/16, 1/22/16, 1/25/16,
 1/26/16, 1/27/16, 1/28/16, 1/29/16**

5. TIME OF SURVEY Day Night
 Weekend Holiday

7. LICENSE NUMBER
1098

3. NAME OF FACILITY
University Place Care Center

4. TYPE OF SURVEY
 Full Post Complaint Other: specify _____

6. STREET ADDRESS
5520 Bridgeport Way West

CITY STATE ZIP CODE
Tacoma WA 98467

NOTE: According to RCW 18.51.060, the Department is authorized to deny, suspend or revoke a license and/or assess monetary fines for deficiencies cited in this report.

8.	9. WASHINGTON ADMINISTRATIVE CODES 388-97	10. CODE OF FEDERAL REGULATION 42 CFR 483.	11. FEDERAL DATA TAG NUMBER	12. REPEAT DEFICIENCY FROM SURVEY DATED	13. NEW CITATION ON POST SURVEY	14. LICENSEE'S PLANNED DATE OF CORRECTION
<input checked="" type="checkbox"/> The requirements of the following WAC's and corresponding CFR's were not met. The text of the statements of deficiencies and the licensee's plan of correction may be read on CMS form 2567, dated: <u>1/29/16</u> . **Licensee must complete column 14. <input type="checkbox"/> The following deficiencies were determined to be corrected.	-0860 (1)(b)	10(e)(1-3)	164		<input type="checkbox"/>	
	-0640 (9)	13(c)(1)(ii)	225		<input type="checkbox"/>	
	-0940 (1)	15 (f)(1)	248		<input type="checkbox"/>	
	-0940 (3)(a)-(c)	15 (f)(2)	249		<input type="checkbox"/>	
	-0960 (1)	15 (g)(1)	250		<input type="checkbox"/>	
	-1000 (1)(b)	20(b)(i)-(xviii)	272		<input type="checkbox"/>	
	-1920 & -1960	20(m)	285		<input type="checkbox"/>	
	-1060 (3)(b)	25 (c)	314		<input type="checkbox"/>	
	-1060 (3)(g)	25 (h)(2)	323		<input type="checkbox"/>	
	-1060 (3)(i)	25 (j)	327		<input type="checkbox"/>	
-1060 (3)(k)(i)	25 (l)(1)	329		<input type="checkbox"/>		
-1100 (3) & -2980	35 (i)(2)	371		<input type="checkbox"/>		

15. SURVEYOR'S SIGNATURE(S)

SIGNATURE <i>Isotella Maestas</i>	DATE <i>2-12-16</i>	SIGNATURE <i>Edwards</i>	DATE <i>2/12/16</i>
SIGNATURE	DATE	SIGNATURE	DATE

16. LICENSEE OR AGENT

SIGNATURE OF LICENSEE (OR AGENT) <i>Patricia McDonald</i>	TITLE <i>Administrator</i>	DATE <i>2/19/16</i>
--	-------------------------------	------------------------