

1102

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505257	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/05/2013
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NAME OF PROVIDER OR SUPPLIER ALDERWOOD MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 3600 EAST HARTSON AVENUE SPOKANE, WA 99202
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Alderwood Manor on 4/1/13, 4/2/13, 4/3/13, 4/4/13, and 4/5/13. A sample of 33 residents was selected from a census of 58. The sample included 29 current residents and the records of 4 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>██████████ R.N., B.S.N. ██████████ R.N., B.S.N. ██████████ B.S.W. ██████████ R.N., B.S.N.</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging and Long-Term Support Administration (AL TSA) Division of Residential Care Services, Dist. 1, Unit A 316 West Boone Avenue, Suite 170 Spokane, Washington 99201-2351</p> <p>Telephone: (509) 323-7300 Fax: (509) 329-3993</p> <p><i>[Signature]</i> Residential Care Services Date 4/22/13</p>	F 000	<p><i>This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility and, such liability is hereby specifically denied. The submission of the plan does not constitute agreement by the facility that the surveyor's findings and/or conclusions are accurate, that the findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied.</i></p> <p>RECEIVED MAY 06 2013 DSHS AD SA RCS SPOKANE WA</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Executive Director	(X6) DATE 5/1/13
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>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.</p> <p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance 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>	F 225	<p>F 225 (D) <i>How the nursing home will correct the deficiency as it relates to the resident</i> Staff L no longer cares for resident #36</p> <p><i>How the nursing home will act to protect residents in similar situations</i> No other residents have been affected by this practice</p> <p><i>Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur</i> In-Service staff on protecting residents from abuse with the importance of following the plan of care; In-Service department managers on the abuse investigation process</p> <p><i>How the nursing home plans to monitor its performance to make sure that solutions are sustained</i> DNS and/or ED to perform weekly audits to ensure staff L does not care for resident #36 weekly x4 weeks, then monthly x3 months; as allegations occur, DNS/ED will audit these residents to ensure they feel safe in their environment</p> <p><i>Date when corrective action will be completed</i> 5/15/13</p> <p><i>The title of the person responsible to ensure correction</i> The Executive Director is responsible to ensure corrective actions</p>	5/15/13

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F 225	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed thoroughly investigate and protect of 1 of 4 residents (#36) reviewed for allegations of abuse in a sample of 33. Findings include:</p> <p>Resident #36 had diagnoses including [REDACTED] with [REDACTED], [REDACTED] and [REDACTED]. The resident required extensive assistance with most activities of daily living and had memory impairment.</p> <p>During an interview on 4/1/13 at 11:30 a.m., the resident said that she was afraid of Staff #L because of the way she responded to her needing help a few nights before. The resident said the staff member had a "murderous" look on her face. She reported the incident to facility staff and said she didn't want Staff #L coming in her room again. However, she said she saw the staff member earlier on 4/1/13 but was not able to say whether she was in her room or not.</p> <p>Per review of the facility investigation, the incident occurred on 3/27/13. The resident was interviewed as part of the investigation and she stated Staff #L was harsh and she was frightened by her. There was no statement from Staff #L regarding her interaction with the resident.</p> <p>In an interview on 4/1/13 at 2:00 p.m., Staff #E confirmed that Staff #L worked with the resident on the evening of 3/31/13, after it was determined she would not work with the resident any longer.</p> <p>The facility did not ensure the resident was protected after the staff member returned to work which placed the resident at risk for further</p>	F 225		
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F 225 F 242 SS=D	Continued From page 3 potential abuse. 483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to allow a resident the right to make choices regarding routines important to that resident for 1 of 3 residents (#138) in a sample of 33 reviewed for choices. Findings include: Resident #138 had a diagnoses that included a [REDACTED]. Per record review, the resident was alert and oriented and able to make her needs known. She was extensive assist with most activities of daily living. Per record review, an assessment for daily preferences dated 3/22/13 documented the resident considered it "very important" to choose her own bedtime. Per interview on 4/2/13 at 9:15 a.m., the resident stated she did not always have a choice of when she got up in the morning or went to bed at night. She stated that she had a routine she wanted followed which included being up and ready for therapy by 7:00 a.m. She stated she sometimes would have a different staff person	F 225 F 242	F 242 (D) <i>How the nursing home will correct the deficiency as it relates to the resident</i> Resident #138 now has requested bed-time routine on her plan of care and is followed per her preference <i>How the nursing home will act to protect residents in similar situations</i> Other residents had the potential to be affected by this practice; other residents were assessed for their personal routine choices of bed time and showers, and these routines were placed on their plan of care and the NAC's care guide <i>Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur</i> In-Service staff to ensure the residents personal choices of their routines is honored; the resident's choices are reflected on their plan of care the the NAC's care guide <i>How the nursing home plans to monitor its performance to make sure that solutions are sustained</i> RCM's will audit to ensure that staff is following the resident's personal routine choices; audits weekly x4 weeks, then monthly x3 months; DNS will review results in facility PI Committee <i>Date when corrective action will be completed</i> 5/15/13 <i>The title of the person responsible to ensure correction</i> The Executive Director is responsible to ensure corrective actions	5/15/13	

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F 242	<p>Continued From page 4</p> <p>every day and they wouldn't know her routine and therefore she would not be ready in time. The resident was frustrated and felt she was put on the same schedule as everyone else.</p> <p>Continuing with the interview, the resident stated she preferred to go to bed at 10:00 p.m. and staff often put her to bed at 7:00 p.m. and she would like to have her showers in the mornings but staff would never consistently come get her for morning showers.</p> <p>Per review of the resident's plan of care, nothing was documented in regards to her preference on waking up, bed time or showering times.</p> <p>Per interview on 4/5/13 at 11:20 a.m., Staff #G stated the residents that are able to make their needs known did not necessarily have their preferences on the plan of care. She stated since they are able to speak for themselves then they would just let the staff know their preference.</p> <p>Failure to allow a resident her right to make choices in her routine frustrated the resident because she repeatedly had to explain to staff her choices which placed her at risk for a diminished quality of life.</p>	F 242		
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p>	F 279		

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F 279	<p>Continued From page 5</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on on observation, interview, and record review, it was determined the facility failed to develop comprehensive care plans related to pain, use of an indwelling urinary catheter, diabetes, and insomnia for 3 of 17 residents reviewed for care planning (#20, 35, 71) in a sample of 33. Findings include:</p> <p>1. Resident #20 had diagnoses including a [REDACTED] and recent [REDACTED]. The resident required extensive assistance with most activities of daily living and was able to make decisions independently. Per record review, the resident was admitted on 3/9/13 for short term rehabilitation related to hip surgery. Per the temporary plan of care dated 3/9/13, the resident was noted to have pain related to her [REDACTED] and had an [REDACTED] in place. Per record review, the resident had her [REDACTED] on 3/11/13. On 3/15/13 the</p>	F 279	<p>F 279 (D) <i>How the nursing home will correct the deficiency as it relates to the resident</i> Resident #20's plan of care has been updated to reflect interventions relating to her Foley catheter; Resident #71's plan of care now includes goals and interventions regarding his diabetes; Resident #35 currently has an insomnia care plan with non-medication interventions as well as medication interventions</p> <p><i>How the nursing home will act to protect residents in similar situations</i> Other residents had the potential to be affected by this practice; residents with Foley catheters were assessed for discomfort/pain and updated care plan as such; care plans of residents with dx of diabetes were audited to ensure goals and interventions were in place; residents with a dx of insomnia were audited for care plans to ensure medication and non-medication interventions are in place</p> <p><i>Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur</i> LN in-serviced on Foley catheters and ensure a plan of care is present to address pain/discomfort along with other interventions in care of a Foley catheter; in-serviced LN on ensuring residents with dx of diabetes are care planned for problems, goals and interventions; LN in-serviced on ensuring residents with dx of insomnia have a care plan to include insomnia with interventions to include medications and non-medications</p>		

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F 279	<p>Continued From page 6</p> <p>resident complained she was having difficulty urinating and discomfort in her abdomen. Between the dates of 3/15/13 and 4/1/13, the resident had her [REDACTED] 3 times secondary to difficulty urinating and discomfort.</p> <p>In an interview on 4/2/13 at 1:30 p.m., the resident stated she had [REDACTED] in her [REDACTED] at times, but lately most of her discomfort was from her [REDACTED]</p> <p>On 4/3/13 at 1:15 p.m., the resident was sitting in her room in her wheelchair. The resident stated she was "doing okay" that day except her [REDACTED] was bothering her.</p> <p>In an interview on 4/4/13 at 11:30 a.m., Staff #H confirmed the resident complained of discomfort related to her issues with urination.</p> <p>There was no documentation on the comprehensive plan of care addressing the residents ongoing difficulty voiding and need to continue to assess the resident's [REDACTED] use. There was no documentation addressing the resident's discomfort from the [REDACTED] or individualized interventions which placed the resident at risk for ongoing discomfort and decreased quality of life.</p> <p>2. Resident #71 was admitted on [REDACTED] 13. Diagnoses included [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED] and [REDACTED]. The resident was able to make needs known and required assistance with activities of daily living, transfers, and able to self-propel a wheelchair.</p> <p>The minimum data set (MDS) completed by the facility on 3/22/13 included an assessment of resident's preferences. The resident indicated it was important for him to have input in his care.</p>	F 279	<p><i>How the nursing home plans to monitor its performance to make sure that solutions are sustained</i></p> <p><i>RCM's will audit residents with Foley catheters to ensure a care plan is present and pain is addressed; MDS nurse/DNS will audit residents with DM care plans to ensure problems, goals and interventions are in place; MDS nurse/DNS will audit residents care plans that have a dx of insomnia and ensure that medication and non-medication interventions are in place; audits will be weekly x 4 weeks, then monthly x 3 months; DNS will review audit results in the facility PI Committee</i></p> <p><i>Date when corrective action will be completed</i></p> <p><i>5/15/13</i></p> <p><i>The title of the person responsible to ensure correction</i></p> <p><i>The Executive Director is responsible to ensure corrective actions</i></p>	5/15/13

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F 279	Continued From page 7 A record review of the resident's care plan included no goals/interventions or approaches identified for management of the resident's [REDACTED]. The resident was admitted to the facility following an incident related to his [REDACTED]. The facility did not identify or include in the resident's care plan problems/interventions and goals to manage/educate and monitor the residents [REDACTED]. 3. Resident #35 had diagnoses including [REDACTED], [REDACTED] and [REDACTED]. Per record review, the resident had no memory problems, required limited to extensive assistance with activities of daily living, and had [REDACTED] for which the resident received a medication for sleep. Per record review, the most recent facility assessment identified the resident's sleeping problems and noted the medication was well tolerated. Review of the resident's physician visit on 3/6/13 revealed the physician evaluated the resident's [REDACTED] and reviewed the resident's [REDACTED] as a possible contributing factor. Per record review and interview with Staff #T on 4/5/13, the facility did not develop a comprehensive care plan to address the resident's [REDACTED] including interventions to promote [REDACTED] in addition to medications.	F 279		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.	F 327		

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F 327	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by: Based observation, interview, and record review, it was determined the facility failed to ensure a resident received sufficient fluid intake to maintain proper hydration for 1 of 2 residents (#26) in a sample of 33. Findings include:</p> <p>Resident #26 had diagnoses that included [REDACTED] and [REDACTED]. Per record review, the resident had no memory impairments and was able to make her needs known. The resident was extensive assist with most activities of daily living and needed supervision while eating and/or drinking.</p> <p>Per assessment dated 2/26/13, the resident was on thickened liquids related to significant swallowing issues. The resident needed encouragement to eat and was to be monitored every 2 hours and encouraged to take in fluids.</p> <p>Per review of the nutrition assessment dated 3/4/13, the resident's fluid needs were estimated to be 1590 milliliters (ml) to 1749 ml.</p> <p>Per interview on 4/1/13 at 2:30 p.m., the resident was asked "do you receive the fluids you want between meals?", the resident responded she only got fluids with her meals. She stated that her mouth was dry and she just didn't take in the fluids that she should.</p> <p>Per observation on 4/2/13 and 4/3/13 during snack rounds, the resident was not offered and did not receive fluids.</p> <p>Per review of the meal monitor for March 2013, the resident's fluid intake on average ranged from 480 ml to 840 ml. The resident had 3 days during the month when she received around</p>	F 327	<p>F 327 (D) <i>How the nursing home will correct the deficiency as it relates to the resident</i> <i>Resident #26 receives fluids with meals and between meals</i></p> <p><i>How the nursing home will act to protect residents in similar situations</i> <i>Other residents had the potential to be affected by this practice; residents that require thickened fluids are offered fluids with meals and offered throughout the day</i></p> <p><i>Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur</i> <i>In-serviced staff on ensuring resident who require thickened fluids are offered fluids with meals and offered throughout the day</i></p> <p><i>How the nursing home plans to monitor its performance to make sure that solutions are sustained</i> <i>RMC's will audit residents who require thickened liquids to ensure they are receiving adequate fluids throughout the day; audits will be completed weekly x 4 weeks, then monthly x 3 months; DNS will review results of audits with the facility PI Committee</i></p> <p><i>Date when corrective action will be completed</i> <i>5/15/13</i></p> <p><i>The title of the person responsible to ensure correction</i> <i>The Executive Director is responsible to ensure corrective actions</i></p>	5/15/13

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F 327	Continued From page 9 1000 ml. Per interview on 4/4/13 at 1:30 p.m., Staff #O stated that when residents are on thickened fluids, staff would obtain the fluids for the residents off of the nurses cart. Staff were to pass the fluids during snack rounds. On 4/5/13 at 1:15 p.m., Staff #N stated that she would try and give Resident #26 sips of fluid throughout her shift and at times the resident will refuse. On 4/5/13 at 1:30 p.m., Staff #E stated that residents were to get their thickened fluids during snack rounds. She stated only the amount of fluid the resident takes at meals is documented, not the fluids they consume at snack time. The facility failed to provide and encourage thickened liquids for the resident consistently which placed her at risk for dehydration.	F 327			
F 329 SS=D	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 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. 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	F 329			

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F 329	<p>Continued From page 10</p> <p>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 observation, interview and record review, it was determined the facility failed to adequately monitor the medication regime for 2 of 10 Sampled Residents (#s71 & 137) reviewed for unnecessary medications of the 33 residents. These failures placed the residents at risk for medications in excessive and/or ineffective doses and/or unnecessary medications.</p> <p>Findings include:</p> <p>1. Resident #71 was admitted on [REDACTED]/13 with diagnoses included [REDACTED], [REDACTED], [REDACTED], [REDACTED] and [REDACTED]. The resident was able to make needs known. The facility assessment on 3/22/13 indicated it was important for the resident to have input in his care.</p> <p>The resident's medications included physician orders for scheduled daily [REDACTED] to be [REDACTED] three times daily before meals, a sliding scale dose of [REDACTED] at meals and scheduled [REDACTED] prior to bed time.</p> <p>A record review of the medication administration record documented by nursing staff noted the resident often refused the scheduled [REDACTED] ordered before meals for "fear</p>	F 329	<p>F 329 (D)</p> <p><i>How the nursing home will correct the deficiency as it relates to the resident</i> Resident #71 has had his insulin medication adjusted; Resident #137 is now receiving his blood pressure and pulse checked prior to administration of his blood pressure medication and given accordingly; Resident #137 is now having every shift documentation of his behaviors</p> <p><i>How the nursing home will act to protect residents in similar situations</i> Other residents had the potential to be affected by this practice; residents with dx of DM were reviewed for unnecessary insulin orders; residents receiving medications in which vital signs need to be checked prior to administration were checked and medications administered accordingly; other residents receiving behavior medication have behaviors documented every shift</p> <p><i>Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur</i> LN in-serviced on following the policy of notifying the MD of potential of unnecessary drugs; in-serviced on the proper documentation of refusal of medications</p>	
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NAME OF PROVIDER OR SUPPLIER ALDERWOOD MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 3600 EAST HARTSON AVENUE SPOKANE, WA 99202		
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F 329	<p>Continued From page 11 of running a low blood sugar".</p> <p>The record review of the nursing progress note dated 3/22/13 included an entry by Staff #J that the physician would be called regarding the [REDACTED]. The next entry dated 3/23/13 by Staff #J included comment by the resident that he had always been on sliding scale [REDACTED] and was not comfortable with routine scheduled [REDACTED] scheduled before meals.</p> <p>The nurse progress notes reviewed 3/15/13 thru 4/4/13 revealed no information from staff regarding follow up with the physician on held [REDACTED] doses or the residents expressed concerns.</p> <p>Staff #H on 4/3/13 at 11 a.m. said in an interview that the expectations for nurses are to review the blood sugars, inform the doctor of concerns, and if medication was held they were to document in the MAR, progress notes and inform the physician.</p> <p>A confirming interview was held with Staff #J on 4/4/13 at 1:40 p.m. She said that she had only spoken to the physician one time since the residents admit and it was in reference to a new pain medication order.</p> <p>This failure placed the resident at risk for excessive and /or ineffective dosing and monitoring of medications that were not needed which increased the risk for adverse side effects and less than optimal medication effectiveness.</p> <p>2. Resident #137 was admitted to the facility on [REDACTED]/13 with diagnoses including [REDACTED], [REDACTED], aftercare for a [REDACTED], [REDACTED], and unspecified [REDACTED].</p> <p>The facility assessment on 3/13/13 indicated the resident had episodes of physical</p>	F 329	<p><i>How the nursing home plans to monitor its performance to make sure that solutions are sustained</i></p> <p><i>RCM/DNS will audit residents with the dx of DM for refusal of holding of insulin to ensure MD was notified; RCM/DNS/SS will audit residents with behavior medications for every shift documentation of behaviors; RCM/DNS will audit for medications that require vital sign prior to administration and ensure they are completed; audits will be completed weekly x 4 weeks, then monthly x 3 months; DNS will review audit results with the facility PI Committee</i></p> <p><i>Date when corrective action will be completed</i></p> <p><i>5/15/13</i></p> <p><i>The title of the person responsible to ensure correction</i></p> <p><i>The Executive Director is responsible to ensure corrective actions</i></p>	C/15/13	

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F 329	<p>Continued From page 12</p> <p>aggressiveness that did not impact on others or interfere with his care.</p> <p>Observation of the resident throughout the day from of 4/1/13 - 4/05/13 he was asleep in bed. The facility had placed one to one staff with the resident for recent repeated falls and alleged incidents of aggressive behaviors toward other residents.</p> <p>A record review of the resident's physician orders included medications for [REDACTED], blood thinning, blood pressure, [REDACTED], [REDACTED], [REDACTED], [REDACTED], and [REDACTED].</p> <p>Prior to administration of the twice daily dose of blood pressure ([REDACTED]) medication, the resident's vital signs of blood pressure and pulse were to be measured. The ordered parameters for the medication were to hold the dose if systolic pressure was 110 or less and pulse rate less than 60 as the medication can cause low blood pressure.</p> <p>The medication administration record reviewed for 3/6/13 - 4/5/13 indicated staff documented vital signs 6 days on evening doses only from 3/23/13 - 3/28/13.</p> <p>On 4/04/13 during an interview, Staff #H confirmed that staff should take the vital signs prior to administering the medication. The resident's [REDACTED] medication ([REDACTED]) orders were changed on 4/1/13; the [REDACTED] a.m. and 12 noon dose were increased to 50 milligrams (mg) twice daily.</p> <p>Staff # F on 4/4/13 clarified in an interview, the [REDACTED] was twice daily only and the resident was starting [REDACTED] sprinkles because of his behaviors at night.</p> <p>Record review of March 2013 behavior monitor flow report the night staff documented</p>	F 329		
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F 329	Continued From page 13 two days of behaviors and no behaviors from 4/1/13 - 4/5/13 on day, evening or night shift. The failure of the facility to monitor the vital signs parameters, and report and record behaviors as identified on the care plan placed the resident at risk for excessive and /or ineffective dosing and monitoring of medications that were not needed which increased the risk for adverse side effects and less than optimal medication effectiveness.	F 329			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441	F 441 (E) <i>How the nursing home will correct the deficiency as it relates to the resident</i> Staff is following proper hand hygiene during cares with resident #139; staff are following proper hand hygiene in the dining rooms <i>How the nursing home will act to protect residents in similar situations</i> No other residents have been affected by this practice <i>Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur</i> Staff in-serviced on proper hand hygiene with personal cares of resident; LN in-serviced on proper hand hygiene with wound care; staff in-serviced on proper hand hygiene during meal assistance		

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F 441	<p>Continued From page 14</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to consistently perform proper hand washing before and after direct resident contact for 1 resident (#139) in a sample of 33 and before and after handling food of all residents in the North dining room. This failure placed the residents at risk for transmission of infection.</p> <p>Findings include:</p> <p>1. Resident #139 was admitted to the facility on 2/13 with diagnoses including _____ pressure, _____, _____, _____, and _____. He required assistance with activities of daily living.</p> <p>The facility assessment evaluated the risk for the resident's skin on admission and interventions included dressing changes and/or application of ointment to wounds daily.</p> <p>Prior to the daily dressing change of the resident wounds on 4/2/13 Staff #A and Staff #B assisted the resident with incontinent care. The staff wore gloves and changed the gloves before</p>	F 441	<p><i>How the nursing home plans to monitor its performance to make sure that solutions are sustained</i></p> <p><i>RCM/DNS will audit for proper hand hygiene during resident cares and wound care; Dietary Manager/ED will audit for proper hand hygiene during meal assistance; audits will be weekly x 4 weeks, then monthly x 3 months; DNS will review audit results with the facility PI Committee</i></p> <p><i>Date when corrective action will be completed</i> 5/15/13</p> <p><i>The title of the person responsible to ensure correction</i> <i>The Executive Director is responsible to ensure corrective actions</i></p>	5/15/13	

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

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F 441	<p>Continued From page 15</p> <p>and after assisting the resident. Staff #B gathered the bag of soiled linen, removed her gloves and left the room without washing her hands. Staff #A removed her gloves, placed on a clean pair of gloves and began dressing changes on the resident's foot wounds. Staff # A told surveyor "I usually go from clean to dirty, but this time I'm not."</p> <p>A record review of the facility's general infection control guidelines included staff are to wash hands before and after all procedures. Wear gloves when appropriate.</p> <p>The facility staff failed to perform hand hygiene before and after assisting a resident with personal care and prior to and after wound care. This failure placed the resident at risk for infection.</p> <p>2. During general observation of dining on the North Wing on 4/01/13 staff served lunch trays, assisted with setting up meals, opened roll packets, split the rolls, and placed butter on the rolls using bare hands. Staff did not wear gloves or use hand sanitizer between residents.</p> <p>Staff #E in a conference on 4/5/13 confirmed that staff are to perform hand hygiene and/or wear gloves when assisting residents in care and dining</p> <p>The facility failed to perform hand hygiene and/or wear gloves while assisting residents with meals. This failure placed the residents at risk for infection.</p>	F 441			