

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

PRINTED: 10/21/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505188</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF FEDERAL WAY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1045 SOUTH 308TH STREET FEDERAL WAY, WA 98003</b>	
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>This report is the result of an unannounced Off-Hours Quality Indicator Survey conducted at Life Care Center of Federal Way on 10/08/13, 10/09/13, 10/10/13, 10/11/13, 10/14/13 and 10/15/13. The survey included data collection on 10/14/13 from 4:45 a.m. to 8:00 a.m. A sample of 23 current residents was selected from a census of 106.</p> <p>The survey was conducted by:</p> <p>██████████ RN, MN ██████████ W ██████████ RN, MSN ██████████ SN ██████████ RN, BSN ██████████ MN</p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging and Adult Services Administration Residential Care Facilities Region 2, Unit F 20425 72nd Avenue South, Suite 400 Kent, Washington 98032-2388</p> <p>Telephone: (253) 234-6000 Fax: (253) 395-5070</p> <p>Residential Care Services _____ Date _____</p>	F 000	<p><b>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 is hereby specifically denied. The submission of this 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.</b></p> <p><b>Please accept this Plan of Correction as our credible allegation of compliance. Our compliance will be achieved by the date identified on the plan of correction.</b></p> <p style="text-align: right;"><b>11/28/13</b></p>

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

Danni Orme, Executive Director 10/30/13

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 166 SS=D	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to resolve grievances of reported missing items for one (#95) of two sampled residents of 24 residents who were interviewed about personal property. This failure placed residents at risk of not having prompt resolution to grievances and loss of personal property.</p> <p>Findings include: According to the facility Lost Property Policy and Procedure any staff member, family member or resident could complete a grievance or missing article form which would then be given to the Social Services department. Social Services would facilitate a search, designated staff would complete an investigation and follow up would be documented on the form and given to the Executive Director (ED) for final review and signature. The form would then be placed in the grievance/missing article binder. Social Service staff would communicate resolution to the resident and document on the form. Replacement or reimbursement of items not found would be at the discretion of the ED.</p> <p>RESIDENT #95 In an interview on 10/08/13 at 2:52 p.m. Resident</p>	F 166	<p>F 166</p> <ol style="list-style-type: none"> <li>Residents # 95 cost of replacement of items has been reimbursed.</li> <li>Facility-wide audit was completed to ensure that other residents are not missing any personal property that has not been reported.</li> <li>All staff training on facility concern and comment forms and missing personal belongings policy and procedures.</li> <li>Random residents interviews weekly x 4 weeks and monthly x 3 months to determine closure to reported lost items. Results to be submitted to PI committee for review.</li> <li>The Executive Director or designee will be responsible.</li> <li>Date of compliance is 11/28/13</li> </ol>	11/25/13	

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F 166	<p>Continued From page 2</p> <p>#95 indicated she had missing items which she had reported to staff. When asked if staff had told her they were looking for the missing items, Resident #95 replied, "They don't look, they have too much work to do. I don't expect them to, I go down and look myself."</p> <p>When asked what items were missing Resident #95 responded, "One thing that hurt my feelings, my niece ran over to the store and bought me a bathrobe. I got something on it, sent it to the laundry and I've never seen it again. I'm also missing a pair of pants. I used to have eight pairs of light blue jeans and now I have none." Resident #95 said she had reported the clothing missing "to the people in the laundry" and added "and I look to see if I see anyone is walking around in them."</p> <p>In an interview on 10/10/13 at 1:20 p.m. a Laundry Assistant, Staff S, said she was aware Resident #95 reported missing light blue jeans and she had looked in the laundry and in the resident's closet. Staff S said she had received missing item forms for Resident #95 in the past, but not for the jeans or robe.</p> <p>Review of the Concern and Comment log for the prior six months revealed no entry for Resident #95.</p> <p>In an interview on 10/14/13 at 7:33 a.m. the Social Service Director, Staff O said, "No it hadn't gotten to me. I don't do the Comment and Concern log anymore." Staff O said concerns "were reviewed in the morning meeting and disseminated to appropriate staff."</p> <p>In an interview on 10/15/13 at 9:40 a.m. the</p>	F 166			

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F 250	<p>Continued From page 5</p> <p><b>DENTAL SERVICES</b> <b>RESIDENT #83</b> Resident #83 was admitted to the facility with care needs related to stroke and heart disease. According to the 08/26/13 MDS, staff were, "unable to examine" the resident's oral status. Record review revealed a dental consult dated 10/30/12 which read, "Pt has tooth #14 cusp fx (fracture) to the gumline. Recommend to have tooth #14 extracted...". There was no indication in the record facility staff acted on this dental consult or had any additional dental service provided since 10/30/12.</p> <p>In an interview on 10/15/13 Staff O (Social Services) indicated it was Social Services' responsibility to ensure residents received podiatry and dental services. Staff O was asked to provide evidence the facility addressed the 10/30/12 dental consult or ensured dental services were provided since the 10/30/12. No information was provided. Failure to ensure residents received dental care they were assessed to require placed the resident at risk for unmet dental needs.</p> <p><b>RESIDENT #84</b> In an interview on 10/09/13 at 10:55 a.m., Resident #84 reported he experienced mouth pain associated with a tooth broken at the gum. He reported using a topical pain reliever "every chance I get". He also stated he had lost several teeth recently. He stated it was difficult to chew due to his dental issues and he had given up certain food items that were too difficult to eat. He stated he thought he might have to have his food "blended" if the dental issues continued. He also said there was a dentist who would treat him, however he had been unable to locate</p>	F 250	<p>F250</p> <ol style="list-style-type: none"> <li>Residents # 79 establish with resident perceived obstacles to obtaining his weight. Discuss risk and benefits with resident involved with his option to decline recommendations inclusive of alterations to meeting goals. Update careplan with established resident centered chosen interventions Resident #83 has been referred to dentist and will be seen on her next facility visit. Follow up with recommendations as indicated. Resident #84 SS will reach out to community transport services and dental providers able to accommodate the physical size of resident. Alternatives for pain and diet texture modifications inclusive of MH services will be provided. Resident was offered ROM program. SS will offer education and document alternatives and reason for refusal as indicated.</li> </ol>	11/28/13

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F 250	<p>Continued From page 6 transportation for the appointment.</p> <p>The 03/28/13 Dental Care Area Assessment identified the resident with "some broken teeth, no problems with chewing at this time. He has been seen by dentist in past (related to) his teeth and declined recommendation... Dental consult (as needed) as (resident) allows."</p> <p>Review of dental notes from 2011 and 2012 revealed the resident was referred to an outside dental provider for numerous teeth extractions due to pain, however the facility had been unable to arrange transportation due to the resident's bedbound status and the extractions never occurred. A 04/25/13 dental consult, conducted at the facility, revealed the resident complained of pain to his upper and lower right mouth. He was identified with "rampant decay throughout".</p> <p>A 06/21/13 progress note revealed the dentist was unable to perform extractions at the facility and the resident would need to be referred to an outside provider. On 07/09/13 the facility contacted the outside provider and left a voice mail requesting an appointment. A 08/01/13 progress note indicated this provider was not able to accommodate the resident. The facility noted they would "explore further options." There was no further indication the facility had attempted to arrange for this resident to receive dental services.</p> <p>In an interview on 10/14/13 at 11:27 a.m., Staff O stated she was not aware of the outside provider who was unable to see the resident or the transportation issues. She stated, "I can look to see what options." She was unable to explain why the resident had not received the dental services</p>	F 250	<p>Resident #93 Proceed with a comprehensive pain assessment with follow up referrals as needed</p> <p>Refer resident to therapy services for re-evaluation of ambulation and/or ROM programs</p> <p>2. HIM will review active residents charts retrospectively 60 days to ensure consult recommendations closure. Audits will be conducted for refusals of weights, dental services and restorative programs.</p> <p>3. SW and LNs to be in-serviced of mgmt of residents choice to refuse inclusive of alternatives to ensure meeting of clinical and/or psychosocial needs RCMs to be in-serviced on management of consult recommendations inclusive of closure to follow up services</p>		

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F 250	<p>Continued From page 7</p> <p>he had been assessed to require for the past two and a half years, nor why she had not been involved in attempting to locate services since the 08/01/13 denial.</p> <p>In an interview on 10/15/13 at 10:15 a.m., Staff E, Charge Nurse, stated she had contacted multiple clinics in the past in an attempt to locate someone who could meet the resident's dental needs. She stated she was not aware of anything that had been done since the provider declined to see the resident on 08/01/13.</p> <p><b>REFUSALS</b></p> <p>In an interview on 10/08/13 at 2:44 p.m., Staff AA reported the resident had contractures to both knees but did not receive range of motion services or have a splint device in place as he consistently refused a restorative program.</p> <p>The Restorative CP, dated 06/05/12, identified the resident with contractures to both knees, obesity, depression with poor motivation, and discomfort when moving. The approaches identified the resident was "often noncompliant" with lower extremity range of motion.</p> <p>Restorative notes dated 01/08/13, 04/13/13, 07/03/13 and 10/13 all identified the resident refused any restorative program.</p> <p>The 09/25/13 Social Service quarterly note revealed the resident "continues to stay in bed and does not wish to get up... continues with (an anti-depressant) for depression (as evidenced by) self isolation in room and decreased motivation." This note identified the resident received mental health services and that Social Services would monitor and provide support as needed.</p>	F 250	<ol style="list-style-type: none"> <li>4. HIM will perform random chart audits to determine follow up compliance with consult recommendations. SS will audit residents that refuse weights, dental services and restorative to ensure they understand alternatives. These audits will be performed weekly x4 weeks then monthly x 3 months. Results will be reported to PI</li> <li>5. The Executive Director will ensure ongoing compliance.</li> <li>6. Date of Completion 11/28/13</li> </ol>		

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F 250	Continued From page 8  In an interview on 10/09/13 at 10:15 a.m., Resident #84 stated he had worked with therapy in the past but had become "frustrated" with his lack of progress. He stated the therapy had been discontinued since he had refused to participate due to his frustration.  In an interview on 10/11/13 at 1:33 p.m., the resident stated he had "bad contractures for three years" in his knees. He stated "it got to the point where I had to refuse (therapy due to) very small improvements."  In an interview on 10/11/13 at 2:30 p.m., Staff N stated the resident refused to let staff screen him for a restorative program. She stated staff checked with him quarterly to see if he was willing to participate, but so far he had not agreed.  In an interview on 10/14/13 at 11:27 a.m., Staff O stated she would have to look at the resident's chart to determine if staff had assessed his continued refusals. She stated "as far as I know he just doesn't like to get out of bed." She stated the resident was seen regularly by mental health, but she was not sure if the provider had been made aware of the resident's refusals in order to assist in determining the cause or addressing it. She stated she would contact the provider to ask if she had been involved in addressing the resident's continued refusals related to his contractures. No further information was provided by Staff O related to the facility's attempts to determine the reasons behind the resident's refusals or to develop alternatives to potentially meet his needs.  RESIDENT #93	F 250			

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F 250	Continued From page 9 Resident #93 was admitted to the facility on [REDACTED]/13 for care related to a [REDACTED] replacement. He subsequently had an additional surgery to the [REDACTED]. Both the 04/03/13 and 09/16/13 MDS reflected the resident had not refused care or services.  Staff documented on Nursing Restorative flowsheet Resident #93 had refused the restorative program on 7/04, 07/19, 08/02, 08, 03, 08/04, 08/05, 08/23, 08/24 and 08/28/13. It was noted the resident refused to ambulate "due to his heels hurting." On 09/01 and 09/02/13, there was a note in the resident's record that he declined his restorative program stating "it's too painful to walk it feels like someone is putting cigarettes out on my heels." Resident #93 had a goal of independent mobility in his power wheel chair.  In an interview on 10/15/13, at approximately 1:30 p.m., Staff N (Restorative Nurse) stated Resident #93 was referred to restorative at the end of June. However, he refused to walk and his program was discontinued on 10/07/13.  There was no evidence the facility assessed the resident's reason for refusing, despite clearly documenting the resident refused a walking program related to pain. The facility failed to assess the need to pre-medicate the resident prior to an activity which was identified by staff as causing pain or to consider any additional alternatives which might have allowed him to participate in the restorative program.	F 250			
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS	F 272			

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F 272	Continued From page 10  The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  A facility must make a comprehensive assessment of a resident's needs, using the 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.	F 272	F272  1. Resident # 20 Resident has expired. Resident #83 MDS corrected to indicate depression Resident #79 MDS corrected to delete dementia as diagnosis. Resident #166 MDS corrected to indicate anxiety as a diagnosis. Resident #58 MDS corrected to reflect use of non-drug intervention for pain management. 2. Facility will retroactively review MDS over the previous 30 days for accuracy and make corrections as warranted. 3. Education of MDS coordinators for accuracy of MDS coding. 4. Monthly audits of MDS for accurate diagnosis and non-drug intervention will be conducted x 3 months with remits review at PI committee for establishment of compliance and further recommendations 5. The Director of Nursing or designee will ensure compliance. 6. Date of compliance is 11/28/13	11/28/13	

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F 272	<p>Continued From page 11</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to accurately assess five (#s 20, 83, 79, 166 &amp; 58) of 19 sampled residents of the 23 residents who were included in the Stage 2 Review. Failure to ensure accurate assessments placed residents at risk for unidentified and/or unmet needs.</p> <p>Findings include:</p> <p><b>RESIDENT #20</b> Record review revealed Resident #20 was admitted to the facility on [REDACTED]/13 with care needs related to heart and kidney disease.</p> <p>According to the 07/16/13 Minimum Data Set assessment (MDS), Resident #20 was assessed to have a psychotic disorder. There was no documentation in the record to support the resident had a psychotic disorder.</p> <p>In an interview on 10/10/13 at 1:45 p.m. Staff D, Resident Care Manager, indicated that after speaking with the resident's doctor, she was not sure where the diagnosis of psychosis came from or why it was on the MDS.</p> <p><b>RESIDENT #83</b> Resident #83 was admitted to the facility with care needs related to stroke and heart disease. According to the 03/25/13 MDS, the resident had no depression, despite the initiation of treatment for depression on 01/22/13. In an interview on 10/14/13, Staff H, MDS Coordinator, confirmed the MDS was incorrect and did not reflect the</p>	F 272		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505188</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF FEDERAL WAY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1045 SOUTH 308TH STREET FEDERAL WAY, WA 98003</b>	
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F 272	<p>Continued From page 12 resident's depression.</p> <p>Similar findings were identified for Resident #79, whose 04/22/13 MDS reflected a diagnosis of dementia which Staff D, in an interview on 10/15/13, stated was incorrect.</p> <p><b>RESIDENT #166</b> Review of physician's orders and the September Medication Administration Record revealed Resident #166 received the anti-anxiety medication Clonazepam every night for anxiety and sleep.</p> <p>The 09/15/13 MDS did not reflect the anti-anxiety use. Additionally, the 09/15 and 29/13 MDS did not reflect anxiety as a diagnosis.</p> <p>In an interview on 10/11/13 at 10:45 a.m., Staff H acknowledged the MDS' were inaccurate. She stated each MDS should have identified the resident with anxiety and daily use of an anti-anxiety medication.</p> <p><b>RESIDENT #58</b> In an interview on 10/09/13 at 8:30 a.m. Resident #58 said "I'm in pain every day". Resident #58 indicated the pain was located in the middle of her stomach. When asked what was done for the pain, Resident #58 replied "they have me on morphine, regimented morphine. It takes the high pain, calms it down, but (I'm) still in pain."</p> <p>According to the 07/11/13 MDS, the resident received scheduled and as needed pain medication, but did not receive any non-drug interventions for pain.</p> <p>Review of the Pain Flow Sheet for the seven day</p>	F 272		

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F 272	Continued From page 13 assessment period revealed documentation of non-drug interventions for pain including positioning and gentle range of motion.  In an interview on 10/11/13 at 2:02 p.m. Staff H said the MDS was inaccurate.	F 272			
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's 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).  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to develop and/or revise comprehensive care plans for six (#s 156, 83, 166, 135, 75 & 93) sampled	F 279	F279  1. #156 Care plan has been updated to address current 1) level of bed mobility and assistance needed. 2) alteration to skin integrity status, inclusive of actual interventions and 3) dentition status compensatory interventions. #33 IDT to develop an alteration to mood/behavior careplan with focus on depression inclusive of goals and interventions #166 A. IDT will develop an alteration to mood/behavior care plan with focus on anxiety, depression and/or insomnia inclusive of goals and interventions. B. The residents care plan has been updated to reflect current hydration needs and/or restrictions. #135 IDT will develop a care plan with appropriate interventions addressing dementia with behavioral disturbance.	11/28/13	

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F 279	<p>Continued From page 14</p> <p>residents of the 20 residents whose care plans were reviewed in Stage 2. Failure to establish care plans that accurately reflected assessed care needs and provided direction to staff on the residents' care related to positioning, pressure ulcers, dental needs, mental health, diagnoses and medication use, fluid restrictions and pain placed residents at risk to receive less than adequate care.</p> <p>Findings include:</p> <p><b>RESIDENT #156</b> Resident #156 was admitted to the facility on [REDACTED]/13 with multiple complex medical needs. According to the 08/02/13 Minimum Data Set (MDS), the resident was identified with multiple pressure ulcers and required two person extensive assistance with bed mobility.</p> <p>According to the Pressure Ulcer Care Plan (CP) dated 08/13/13, the resident required one to two person extensive to total assistance with activities of daily living related to immobility and directed staff to "float heels when in bed." Additionally, the CP indicated the presence of "bilateral" lower extremity pressure ulcers.</p> <p>Observations throughout the survey revealed the resident spent most of his time in bed lying on his back. The resident was consistently noted with blue boots on his feet, but his heels were not observed to be floated (lower extremities on pillow to prevent heels from resting on the bed.) The resident was noted with a dressing to the left, but not the right, foot.</p> <p>In an interview on the morning of 10/15/13, Staff D, Resident Care Manager, indicated the CP was</p>	F 279	<p>#75 The IDT will develop a comprehensive care plan addressing pain inclusive of non-drug interventions.</p> <p>#93 Therapy referral to establish baseline of current level of lower extremity function and/or contractures for recommendations towards development of a comprehensive care plan addressing LE function and/or limitations.</p> <ol style="list-style-type: none"> <li>2. Audits of active residents care plans will be conducted for accuracy and timely development.</li> <li>3. Education with MDS coordinator and Resident Care Managers on comprehensive care plan development.</li> <li>4. Audits for timely development and accuracy of care plan conducted monthly based on the MDS schedule x3 months. Audit results presented to PI committee for identification of further recommendations.</li> <li>5. 11/28/13</li> <li>6. Director of Nursing or designee will ensure compliance.</li> </ol>		

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F 279	<p>Continued From page 15</p> <p>not correct in that the resident was no longer extensive to total assistance with bed mobility and was able to change positions while in bed with cueing. Staff D elaborated the intervention of floating heels was not accurate as the resident had blue boots applied while in bed and didn't require floating of the heels. When asked if the resident had bilateral pressure ulcers, Staff D indicated the wounds on the right foot had resolved and the CP should have been updated.</p> <p>Additionally, in an interview on 10/15/13 at 10:15 a.m., Resident #156 stated he had partial dentures which were broken and would like them replaced. Resident #156 was assessed on admission to have missing partial dentures but there was no CP which addressed this issue.</p> <p><b>RESIDENT #83</b> Record review revealed Resident #83 was admitted to the facility with care needs related to stroke and heart disease. Review of physician's orders revealed the resident was started on medications to treat depression in January 2013. Facility staff failed to develop a care plan related to the depression until 04/25/13. Failure to ensure timely development of the CP which reflected the residents status placed this resident at risk for unmet psychosocial needs.</p> <p><b>RESIDENT #166</b> According to physician's orders and the September and October 2013 Medication Administration Record (MAR), Resident #166 received the anti-anxiety medication [REDACTED] nightly for sleep and anxiety and the anti-depressant [REDACTED] for depression. In addition, Melatonin was added on 09/24/13 for insomnia.</p>	F 279		

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F 279	<p>Continued From page 16</p> <p>The Psychoactive Medication and Behavior Monitoring Review, dated 09/05/13, identified the resident received an anti-depressant medication "for depression aeb (as evidenced by) flat affect and pain related". It also identified the use of an anti-anxiety medication "for anxiety aeb agitation and racing thoughts." This review also assessed "ongoing use of anti-depressant and anti-anxiety medications are indicated. Will cont(inue) to monitor and support."</p> <p>The Social Service Assessment, dated 09/09/13, identified the resident was "Lethargic throughout the day. Keeps to herself. Flat affect even through conversation." The resident began receiving mental health services on 10/01/13 due to Major Depressive Disorder including "daily sadness, lack of interest and pleasure, insomnia, feelings of worthlessness, and trouble concentrating."</p> <p>Review of the resident's comprehensive care plans revealed no care plans that addressed her identified anxiety or insomnia. The only CP that addressed depression was the 09/24/13 Psychotropic Medication CP that identified the resident received a "Psychotropic drug use (related to) depression." This goal was that the resident would have "no adverse side effects r/t psychotropic med(ication)". This care plan did not identify the resident's anxiety or insomnia, nor did it identify how the depression manifested or what interventions the facility would implement to address the issues.</p> <p>In an interview on 10/11/13 at 8:59 a.m., Staff O, Social Services Director, stated the resident should have mood and anxiety care plans, as the</p>	F 279			

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F 279	<p>Continued From page 17</p> <p>resident was "very anxious and also depressed...". She stated she was not sure how the care plans "got missed".</p> <p>In addition, review of the 09/24/13 Dehydration and Constipation care plans revealed each contained the approach "Encourage fluid intake with and between meals". According to a Physician Order (PO), the resident was on a two liter fluid restriction, with specific amounts of fluid that were to be provided by the dietary and nursing staff.</p> <p><b>RESIDENT #135</b> Similar findings were identified for Resident #135 who received both an antipsychotic and antidepressant for dementia with behavioral disturbances but for whom the facility failed to develop a care plan related to her mood or behaviors.</p> <p><b>RESIDENT #75</b> In an interview on 10/08/13 at 10:46 a.m., Resident #75 stated she experienced "constant pain but they (staff) do all they can to help me." She identified pain in both legs.</p> <p>According to the 09/26/13 admission MDS, Resident #75 received both scheduled and as needed pain medications. She was assessed to have experienced pain the previous five days that caused her to limit her day to day activity.</p> <p>The Care Area Assessment for pain identified the resident with severe bilateral neuropathy. It also identified the resident did not like to take narcotics and staff were directed to monitor for effectiveness and side effects of pain medications.</p>	F 279			

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F 279	<p>Continued From page 18</p> <p>Review of the resident's comprehensive care plan revealed a Cognitive Loss CP, dated 09/19/13, identified the "resident prefers to avoid narcotics for pain even if pain isn't completely controlled." The Pressure Ulcer CP directed staff to "Observe for pain and medicate (as needed)...". There was no care plan that specifically addressed her pain or interventions staff could implement to attempt to relieve it.</p> <p>In a interview on 10/10/13 at 1:14 p.m., Staff D stated the resident experienced pain. She stated there should have been a care plan that addressed non drug interventions and was unable to explain why one had not been developed.</p> <p><b>RESIDENT #93</b> Resident #93 was admitted to the facility on [REDACTED] 13. According to the 05/26/13 MDS, the resident had functional limitation in Range of Motion (ROM) to one lower extremity (LE) and actively received both Physical and Occupational Therapy (PT /OT). According to the 06/24/13 MDS the resident had experienced a decline, and was now assessed with functional limitation in ROM to both LEs and still required the use of PT and OT. The 09/16/13 MDS reflected the resident continued to have bilateral LE limitation in ROM, but no longer received the benefit of PT/OT.</p> <p>According to 09/24/13 therapy notes, Resident #93 had, "[REDACTED] hip and knee...contractures influencing ability to transfer and ambulate. A therapy plan of treatment, dated 09/24/13, goal of "The patient will maintain [REDACTED] LE (Active) ROM with self-ROM activities."</p>	F 279			

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F 279	Continued From page 19 According to the Activities of Daily Living CP dated 03/28/13, the resident had a goal of, "resident will not develop any complications related to decreased mobility through next review date." However, there were no indication in the residents CP of the existence of hip/knee contractures nor were there interventions which addressed preventing the worsening of these contractures, despite the identified decline from the 05/26/13 to the 06/24/13 MDS.  In an interview on 10/15/13, at approximately 1:30 p.m., Staff N indicated a Restorative ambulation program but no ROM program was developed for this resident. According to Staff N the ambulation program was discontinued on 10/07/13 due to resident refusals. There was no indication in the CP the resident demonstrated refusals.  In an interview on 10/15/13 at approximately 1:45 p.m., Staff B indicated that there was not a plan to monitor or prevent worsening of the contractures for Resident #93.	F 279	F282  1. #83 careplan and careguides are updated to reflect frequency of weight measurements. Nails have been trimmed by LN. Podiatry referral in place to address toenails. #95 Careplan and careguides have been updated to reflect frequency of weight measurements. (monthly) #23-Careplan and careguides have been updated to reflect frequency of weight measurements. (monthly) #55 Careplan and careguides have been updated to reflect frequency of weight measurements. (monthly) #10 Careplan and careguides have been updated to reflect frequency of weight measurements. (monthly)	11/28/13
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to ensure staff consistently implemented plans of	F 282	2. Weekly nutrition meeting to review weights with warranted referrals for nursing home population. 3. Staff education on the purpose of a comprehensive plan of care and risks on non-adherence.	

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F 282	<p>Continued From page 20</p> <p>care for six (#s 83, 95, 23, 55, 10 &amp; 156) sampled residents of the 20 residents who were included in the Stage 2 review. Failure to implement care residents were assessed to require placed residents at risk for unidentified weight loss, bleeding, and poor hygiene.</p> <p>Findings include:</p> <p><b>RESIDENT #83</b> Resident #83 was admitted to the facility on [REDACTED]/12 with care needs related to stroke, heart disease and diabetes. According to the 03/25/13 Minimum Data Set, Resident #83 required the use of a feeding tube. According to the 07/02/13 Feeding Tube care plan (CP), approaches included, "weights per protocol." According to facility weight monitoring policy/protocol, "weights and heights are obtained within 24 hours of admission/readmission and recorded (in record)" and "weekly weights are obtained for... any resident receiving an enteral feeding." In an interview on 10/11/13, at 9:22 a.m., Staff C (Corporate staff) stated it was facility practice that, "we should get the three (consecutive) days of weights on admission."</p> <p>Review of weight records revealed staff failed to consistently obtain weekly weights. January 2013 listed one weekly weight, February reflected two. There was only one weekly weight listed each for the months of March, April and May. In addition, staff failed to obtain weights for over two weeks after the resident was readmitted from the hospital on 07/01/13. Failure to obtain weights according to the CP placed the resident at risk for delayed identification of weight loss.</p> <p>According to the resident's</p>	F 282	<ol style="list-style-type: none"> <li>1. #156 O.T. referral submitted for safe handling of razor of choice. Razors have been removed and resident has been educated until screened and cleared by O.T.</li> <li>2. Immediate living environment of all residents on anticoagulants reviewed: no recurrence of aforementioned surveyor observation.</li> <li>3. Staff education on actual plan of care recommendations under potential for injury related to anti-coagulant usage.</li> <li>4. Adherence to plan of care will be validated weekly x 4 weeks then monthly x 3 months.             <ol style="list-style-type: none"> <li>a. validation of CP interventions via direct staff interview</li> <li>b. validation of CP interventions via direct resident observation</li> <li>c. On the spot education upon noted deviation of CP will occur.</li> </ol> </li> </ol> <p>Results of audits will be reviewed by PI committee for further recommendations for improvement.</p>	
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F 282	<p>Continued From page 21</p> <p>Hyperglycemia/hypoglycemia CP dated 08/06/12, the resident was to have "Nail care by LN (Licensed Nurse) weekly." Review of Medication Administration Records revealed LN staff documented nail care was done on 10/11/13.</p> <p>Observation on 10/14/13 at 9:01 a.m. revealed Resident #83 lying in bed. The resident's fingernails were noted to be long with some dark matter noted beneath the nails of the right hand. The resident's toenails were long and some were curved at the end of the toes.</p> <p>In an interview on 10/14/13 at 9:01 a.m., Staff E confirmed Resident #83's nails needed to be trimmed and indicated it did not appear the resident had received nail care recently. Failure to implement the CP placed the resident at risk for ingrown toenails and skin tears related to long nails.</p> <p>Similar findings were noted for Resident #s 95, 23, 55, and 10 whose Nutrition CPs instructed staff to "Weigh and observe results weekly". The last documented weight obtained for Resident #95 was 09/09/13, with only one weight obtained in June, July and August 2013. The last documented weight obtained for Resident #23 was 09/25/13 and only one weight was obtained in June 2013. Review of Resident #55's record revealed eight weeks without weights between 06/26/13 and 10/11/13. The last documented weight obtained for Resident #10 was on 09/25/13, with only one weight obtained in June 2013 and no weight obtained between 04/30 and 05/13/13.</p> <p>RESIDENT #156 Record review revealed Resident #156 received</p>	F 282	<p>5. 11/28/13</p> <p>6. Director of Nursing or designee will ensure compliance.</p>		

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F 282	Continued From page 22 anticoagulant medication and had a recent history of stomach ulcer and a gastrointestinal bleed. According to the resident's anticoagulation CP, the resident was identified as "at risk for abnormal bleeding or hemorrhage because of anticoagulation usage." Approaches included, "Instruct resident to... shave using an electric razor due to risk of bleeding."  Observations on 10/11 and 10/14/13 revealed the resident the resident had a double bladed razor at his bedside. In an interview at that time, Resident #156 stated he utilized the razor for shaving. In an interview on 10/14/13 at 10:30 a.m., Staff D indicated the CP should be, but was not, followed.	F 282	F309  1. #79 O.T. referral/screen for reassessment of overt functional needs for medication set up and dining. Care plan updated accordingly. Care guides updated. #93 Comprehensive pain assessment PCP referral for follow imaging diagnostics. PCP referral for follow diagnostics related to gout diagnosis Trial of PRN analgesic with restart of restorative program for ambulation. #120 OT referral for w/c positioning assessment and recommendations for establishing degree to tilt w/c.	11/28/13
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to ensure three of 23 sampled residents received the necessary care and services to attain or maintain the highest practicable level of well being. Failure to ensure Resident #79 received assistance with meals, Resident #120 was	F 309	2. Active residents ADL scores will be reviewed. Residents needing assistance with ADLs will be audited for careplan and careguide accuracy Restorative flowsheets for active residents will be reviewed for identification of refusals with follow up assessments and referrals as needed.	

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F 309	<p>Continued From page 23</p> <p>properly positioned and Resident #93 was assessed for and received interventions for pain had the potential for these residents to experience weight loss, discomfort and pain.</p> <p>Findings include:</p> <p><b>RESIDENT #79</b> Resident #79 was admitted to the facility with care needs related to heart disease. According to the 07/17/13 Minimum Data Set (MDS), Resident #79 required setup help with meals.</p> <p>In an interview on 10/15/13 at 8:12 a.m., the resident indicated staff did not consistently assist him with setting up for meals. A plastic wrapped dessert was noted on the resident's bedside table which he stated was from the previous night's dinner.</p> <p>Observation on 10/10/13 at 1:35 p.m. revealed the resident reclined in bed, his lunch tray in front of him on the overbed table. The milk carton was unopened and two cans of Ensure (liquid nutritional supplement) were present but not open. A cup of what appeared to be bread pudding was covered in plastic wrap.</p> <p>Observation on 10/11/13 at 1:32 p.m. revealed the resident lying in bed on his back trying to open a carton of nutritional juice drink with a fork. There was also a carton of milk on the tray which was unopened. The resident stated, "I want to keep the potato, heat it up, take the soup..." and gesturing to the juice carton stated, "can you open that?" At 1:35 p.m. Staff V (Nursing Assistant) was requested to open the juice, and after attempting to place a straw, discovered the juice was frozen. In an interview at 1:39 p.m. on</p>	F 309	<ol style="list-style-type: none"> <li>3. Staff will be educated on purpose of the careplan, interventions and refusal management.</li> <li>4. Staff will be audited weekly x 4 weeks than monthly x 3 months on careplan interventions and adherence with on the spot education/correction as warranted. Results of audits will be reviewed by PI committee for further recommendations for improvement.</li> <li>5. 11/28/13</li> <li>6. Director of Nursing or designee will ensure compliance.</li> </ol>	

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F 309	<p>Continued From page 24</p> <p>10/11/13 Resident #79 stated, "maybe half to a quarter of the time they help me set up (for meals)".</p> <p>On 10/14/13 at 7:42 a.m. Staff R was observed to bring the resident's breakfast tray and set it on the resident's overbed table. Observation at 7:57 a.m. revealed the resident lying in bed, his breakfast uneaten in front of him. The resident requested at that time to have his pancakes cut so he could eat them. The resident was unsuccessful in his repeated attempts to open the small plastic container which held the pancake syrup. Two cans of unopened Ensure were noted on the resident's overbed table. The resident indicated he couldn't open the cans if he tried. Failure to ensure Resident #79 received the necessary set up assistance with meals detracted from his ability to independently eat his meals.</p> <p>RESIDENT #120</p> <p>According to the 08/29/13 MDS, Resident #120 required extensive assistance of one person for mobility. According to the 03/27/13 fall risk and potential impaired skin integrity Care Plans (CPs), the resident utilized a Tilt N Space (TNS) wheelchair (w/c) for "optimal positioning and pressure relief."</p> <p>On 10/08/13 at 2:23 p.m. Resident #120 was observed sitting in a TNS w/c tilted back approximately 45 degrees. Although the foot rests were in place, both of the resident's feet were observed dangling, not resting on foot rests. Similar findings were observed on 10/10/13 at 8:41 a.m. when the resident's w/c was tilted back and the resident's left foot was dangling. Staff AA, Resident Care Manager, was observed to propel the resident from the hallway outside the</p>	F 309			

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F 309	<p>Continued From page 25</p> <p>dining area to the 400 wing hallway in this position. The resident remained in this position until at least 10:08 a.m. Similar findings were observed on 10/11/13 at 8:54 a.m. when the resident was seated in front of a TV in the dining/activity room, the TNS tilted back 45 degrees, and the resident's left foot dangling. The resident's right foot was observed to be held to the foot rest by just the tip of a blue booty.</p> <p>On 10/10/13 at 12:24 p.m. documentation of a wheelchair evaluation and/or screen was requested from Staff BB who stated none had been conducted. In an interview on 10/14/13 at 5:28 a.m. Staff CC said the resident had been admitted to the facility with the TNS w/c. When informed the resident's feet were observed consistently dangling behind the foot rests, Staff CC indicated the resident should have a wheelchair leg strap to prevent the legs and feet from dangling.</p> <p>On 10/14/13 at 7:46 a.m. Resident #120 was observed seated in the dining room, with a hard foot rest pad, which prevented the resident's legs and feet from dangling behind the w/c foot rests, but now the resident's feet hovered above and no longer rested on the foot rests when seated at a 90 degree angle.</p> <p><b>RESIDENT #93</b> Resident #93 was admitted to the facility on [REDACTED] 13 with diagnoses that included failure to thrive, arthritis, muscle spasm, gout and [REDACTED] surgeries. According to the care plan dated 03/29/13, an identified goal was for the resident to have pain "less than 3 on pain scale/ face scale 1-10". Interventions included "administer/observe for</p>	F 309		

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F 309	<p>Continued From page 26</p> <p>effectiveness and for possible side effects of from PRN pain medication." The 09/16/13 MDS reflected the resident received scheduled pain medication but did not receive as needed (prn) pain medications, nor were there any non-pharmacological interventions provided for pain.</p> <p>Review of Restorative Aide (RA) flowsheets revealed the resident was started on an ambulation program in 06/13 which directed staff to ensure the resident ambulated "3-6 x/week" for a distance of 40 feet. According to RA documents the resident participated in this program ambulating 70-100 feet in 06/13 and 40-140 feet in 07/13. According to RA documents the resident refused ambulation on 08/02, 03, 04 and 05/13. Staff documented on 08/23/13, "pt refuses to amb(ulate) says he has sore heel." Similar documentation was identified for 08/24 and 28/13. The resident did not participate in any ambulation program for the month of August.</p> <p>According to 09/13 RA flowsheets the resident refused to participate at all in the ambulation program. Staff documented on 09/02/13, "rsd declined program due to back and foot. LN (Licensed Nurse) aware." On 09/11/13 staff documented the resident declined the restorative program stating, "too painful to walk, (it feels) like someone is putting cigarettes out on my heels." Despite the resident's frequent complaints of heel pain the facility continued to provide therapy, which the resident frequently refused related to pain in his heel.</p> <p>Nursing therapy notes dated 09/12/13 indicated the resident refused to ambulate due to pain related to a foot wound. "Patient states he does</p>	F 309		
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F 309	Continued From page 27 not want to ambulate due to [REDACTED] ulcer and pain. " In an interview on 10/15/13, Staff N indicated the residents RA program was discontinued on 10/07/13 due to refusals.  According to a 09/24/13 Physical Therapy (PT) evaluation, Resident #93 presented with [REDACTED] ulcer which is painful. Pt declines to ambulate or stand." Staff documented, "The resident reports a pain scale rating of 8/10 (1-10 pain scale measure) for [REDACTED] heel with weight bearing." Despite this assessment, there was no indication staff considered a further evaluation of the pain to rule out gout versus wound or neuropathic pain or attempted any intervention, including utilizing available PRN pain medications.  There was no indication facility staff identified that pain was a contributing factor to the residents refusals, or attempted to pre-medicate prior to ambulation, which might have increased the resident's participation level.  In an interview on 10/15/13 at approximately 1:45 p.m., Staff B acknowledged the facility failed to assess the need to pre-medicate the resident prior to an activity which was identified by staff as causing pain.	F 309	F 312 1. #10 Careplan updated to reflect type of oral care to be performed daily #83 Nail care to fingers and toes provided. Podiatry referral as warranted. #79 Nail care provided 2. Visually Audit all residents for oral care and nail care needs. 3. Staff education on oral hygiene and nail care policy and procedure. 4. Random resident audits to establish satisfaction with oral care (cognitively intact) or visual oral assessment of the impaired residents weekly x 4 weeks and monthly x 3 months Random visual audits to establish compliance with expected nail care weekly x 4 weeks then monthly x 3 months. Results of audits will be reviewed by PI committee for further recommendations for improvement. 5. 11/28/13 6. Director of Nursing or designee will ensure compliance.	11/28/13
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		

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F 312	<p>Continued From page 28</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to provide oral hygiene for one (#10) and nail care for two (#s 83 and 79) of four residents reviewed for Activities of Daily Living, Cleanliness and Grooming who were dependent on staff for care. This failure placed the resident at risk for poor oral hygiene, skin tears and ingrown nails.</p> <p>Findings include:</p> <p>The facility's undated Oral Hygiene Procedural instructions included, "Provide dental care before breakfast and at bedtime. Instruct the resident to rinse his/her mouth out after each meal."</p> <p><b>RESIDENT #10</b> In an interview on 10/09/13 at 8:42 a.m. when asked "How often are your teeth/ dentures/ mouth cleaned?", Resident #10 replied "twice a week."</p> <p>According to the 07/23/13 Minimum Data Set (MDS) Resident #10 had no natural teeth and required extensive assistance of one staff for personal hygiene including oral care.</p> <p>According to the 07/31/13 activities of daily living (ADLs) care plan (CP) the resident had an ADL self care deficit related to impaired mobility and required extensive assist with ADLs. Approaches listed included "assist with oral care daily." The 07/31/13 Oral Care CP noted the resident was edentulous and listed a goal of "resident will not develop any oral/dental complications through next review date". Approaches listed included,</p>	F 312		
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F 312	<p>Continued From page 29</p> <p>"Assist with oral care daily", and "resident does not wear dentures". Neither of the CPs indicated the type of oral care to be provided. The 10/09/13 Care Directive for Resident #10 did not address oral care/hygiene.</p> <p>In an interview on 10/11/13 at 9:10 a.m. when asked if staff had provided oral care that morning, Resident #10 replied, "They do it twice a week and this isn't the day." Resident #10 went on to say oral care was provided on "Wednesday and Saturday." When asked how staff cleaned her mouth, Resident #10 said "They give you a bottle of mouthwash and I rinse my mouth out with it."</p> <p>In an interview on 10/11/13 at 9:58 a.m. when the day shift nursing assistant (NA) assigned to Resident #10 was asked about the resident's oral care, Staff W said "Night shift does that when she gets up."</p> <p>In an interview on 10/14/13 at 5:30 a.m. with the night shift NA assigned to care for Resident #10, when asked if she provided the resident's oral care, Staff X said "No" and commented the resident didn't have any teeth.</p> <p>In an interview on 10/15/13 at 8:51 a.m. when asked about oral hygiene, Staff B indicated the expectation was for staff to follow the resident's CP and/or provide oral care in the morning and in the evening, regardless of dentition, and added staff could offer after meals as well.</p> <p><b>RESIDENT #83</b> According to the 08/26/13 MDS, Resident #83 required extensive one person physical assistance with personal hygiene and had diagnoses which included diabetes.</p>	F 312		

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F 312	<p>Continued From page 30</p> <p>Observation on 10/11/13 at 8:17 a.m. revealed Resident #83 lying in bed. His finger and toenails were noted to be long with brown debris noted beneath some of the nails of the right hand. The resident was unable to answer questions regarding his care.</p> <p>On 10/14/13 at 9:01 a.m., Staff E (Licensed Nurse) was requested to examine Resident #83's finger and toe nails. Staff E, upon observing the residents fingers stated, "oh, those need to be trimmed". When asked if it looked if the resident's nails were trimmed recently, Staff E stated, "It doesn't look like it."</p> <p>Observations revealed the fingernails on the right hand were long and the second, third and fourth fingers had mild to moderate brown debris beneath them. The toe nails on the right and left foot were elongated with partial curving of multiple nails and the great toenails of both feet were thickened and long.</p> <p>In an interview on 10/14/13 at 9:25 a.m., Staff J (Licensed Nurse) indicated he attempted nail care on 10/11/13, but the resident refused. Staff J stated he should have documented this, but instead he documented as if the nail care had been completed.</p> <p>Staff E later reported the resident was cooperative with nail care, but was unable to do the right great toe because it was "too thick". Staff E stated "he is now on the list to be seen by the podiatrist."</p> <p>Similar findings were identified for Resident #79, whose nail care was scheduled on 10/11/13 with</p>	F 312		

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F 312	Continued From page 31 bathing, but was identified on 10/14/13 with long, mildly soiled and jagged nails. This observation was confirmed by Staff D.	F 312	F325	11/28/13	
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE  Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to ensure nutritional parameters were maintained for one (#83) of two residents reviewed for nutrition and a supplemental resident (#79). Failure to ensure weights were obtained, meal and supplement intake were consistently monitored and documented, supplements were provided when indicated and timely dietitian referrals were made resulted in delayed identification of weight loss and delayed interventions which put residents at risk for nutritional decline.  Findings include:	F 325	1. #83 R.D. referral submitted SLP referral submitted Care plan and care guides updated to reflect weekly weights. #79 Care plan and care guides to include: 1) actual level of assistance needed at meal time. 2) when to offer nutritional supplements by the NAC 3) clarification of PCP ordered nutritional supplements 4) weight management frequency with resident education./risk and benefits with alternatives if he declines weight measurements 5) Clarification of PCP ordered supplement to require documentation by nurse of % consumed. 2. Review all active residents weight measurements with referrals as warranted. Audit physician orders for supplements to ensure accuracy and documentation requirements needed.		

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F 325	<p>Continued From page 32</p> <p>Refer to CFR 483.15(g)(1), F-250 Social Services CFR 483.20(k)(3)(ii), F-282, Services by Qualified Persons CFR 483.25, F-309, Provide Care and Services for Highest Well Being</p> <p><b>RESIDENT #83</b> Resident #83 was admitted to the facility on [REDACTED] 12 with care needs related to stroke, heart disease and diabetes. According to the 03/25/13 Minimum Data Set assessment (MDS), Resident #83 was totally dependent on staff for nutritional needs and required the use of a feeding tube. According to the 07/02/13 Feeding Tube care plan (CP), approaches included, "weights per protocol." According to facility weight monitoring policy/protocol, "weights and heights are obtained within 24 hours of admission/readmission and recorded (in record)" and "weekly weights are obtained for... any resident receiving an enteral feeding." In an interview on 10/11/13, at 9:22 a.m., Staff C (Corporate staff) stated it was facility practice that, "we should get the three (consecutive) days of weights on admission."</p> <p>Observations on multiple days through the survey revealed Resident #83 lying in bed, receiving liquid nutrition through a tube. The resident was unable to answer questions regarding his care.</p> <p>Review of weight (wt) records revealed the resident was assessed to weigh 151 pounds (lbs) on 04/17/13 and 147 lbs on 06/17/13.</p> <p>The resident was discharged to the hospital on [REDACTED] /13 and readmitted to the facility on [REDACTED] /13. An RD (Registered Dietician) note dated 07/03/13 indicated, "wts: pending" and a goal of "monitor weekly wts, goal wt maintain and</p>	F 325	<p>3. Nursing staff educated on weight management, meal intake documentation, offering of supplements or alternatives and documentation of supplements. Weights reviewed in house with refusals as warranted and:</p> <ul style="list-style-type: none"> <li>a) determination for weekly weights established</li> <li>b) determination for monthly weights established</li> <li>c) Subsequent RD/SLP/ MH/PCP referrals as determined</li> </ul> <p>RCM will ensure 3 day wts are completed timely RCM will ensure weekly wts are completed timely.</p> <p>4. DNS will review all active residents weekly x 4 weeks and monthly x 3 months with IDT follow up as warranted. Residents triggering wt loss/gain will be reviewed monthly x 3 months</p>	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505188</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/15/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF FEDERAL WAY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1045 SOUTH 308TH STREET FEDERAL WAY, WA 98003</b>	
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F 325	<p>Continued From page 33</p> <p>gradual gain." The RD reviewed the resident again on 07/10/13, documenting, "awaiting wt... continue with current poc (plan of care)."</p> <p>Facility staff failed to obtain a weight for this resident until 07/16/13, more than two weeks after readmission to the facility. On 07/16/13 staff assessed Resident #83 to weigh 137 lbs, a 14 lb (over 9%) weight loss since the 04/17/13 weight and a 10 lb (over 6%) weight loss in 30 days. According to the facility Nutrition Intervention policy, a significant/severe weight loss is identified as "greater than 7.5% in 90 days" and "greater than 5%" in 30 days." Failure to obtain wts according to the resident's plan of care resulted in a delay in identification of wt loss.</p> <p>There was no indication staff addressed this weight loss until 07/24/13 when a Nutrition At Risk (NAR) note indicated, "res(ident) cont(inues)... on tube feeding was hospitalized for aspiration pneumonia, pre-hospital wt 147 lbs, wt in (hospital) 143#, wt today 136 lbs... spoke to RD informed of cont wt loss...".</p> <p>There was no nutritional intervention for the weight loss identified on 07/16/13 until an RD note dated 07/31/13 (a full week after the 07/24/13 NAR note and two weeks after the wt was obtained) recommended an "increase tube feeding to support desirable wt gain."</p> <p>Laboratory results dated [REDACTED]/13, two days after readmission to the facility, reflected albumin and total protein levels (reflection of nutritional adequacy) were within normal limits. Laboratory results drawn on 08/05/13 (four days after tube feeding rates were increased) indicated a low albumin of 3.1 (normal range of 3.5 to 5.0) and a</p>	F 325	<p>Meal intake documentation to be audited weekly x 4 weeks then monthly x 3 months. HIM will audit new admits and readmits to ensure daily weights x 3 days. Weekly x 4 weeks then monthly x 3months. Results of audits will be reviewed by PI committee for further recommendations for improvement.</p> <p>5. 11/28/13 6. Director of Nursing or designee will ensure compliance.</p>	

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F 325	<p>Continued From page 34</p> <p>low total protein of 5.8 (normal range 6.3-8.2). Failure to provide timely interventions after a wt loss was documented placed the resident at risk for continued wt loss and nutritional decline.</p> <p>In an interview on 10/11/13, at 9:22 a.m. Staff C was unable to explain why staff did not obtain Resident #83's wts timely or why there was a delay in addressing the significant wt loss.</p> <p><b>RESIDENT #79</b> Resident #79 was admitted to the facility with care needs related to heart disease. According to the 07/17/13 MDS, Resident #79 required set up help with meals.</p> <p>Observation throughout the survey revealed the resident did not consistently receive required set up with meals and did not receive nutritional supplements or alternates when less than 50% of the meal was consumed. Failure to provide adequate meal set up detracted from the resident's ability to consume his meals.</p> <p>Record review revealed the resident's last documented wt on 07/18/13 was 190 lbs. There was no indication in the record staff obtained wts or documented refusals. On 10/14/13 at 10:58 a.m., Resident #79 consented to being weighed. According to Staff Q, the resident weighed 180.8 lbs, a nine lb (4.8%) unplanned loss in less than 60 days. Failure to obtain resident wts placed the resident at risk for delayed identification of wt loss.</p> <p>Review of Resident #79's meal intake records revealed the resident, from 10/01/13 to 10/15/13, had no meal intake recorded on 19 of 42 meals, 25% or less for 14 of 42 meals, 50% for seven of</p>	F 325			

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F 325	<p>Continued From page 35</p> <p>42 meals and 75% for two of 42 meals. According to these records, the resident was offered snacks three times a day. Staff documented the resident consumed 25% or less of the snacks on 34 of 42 occasions. Similar findings were identified for the month of September.</p> <p>According to Physician's Orders dated 08/26/13, staff were directed to provide "206 juice (a calorie and protein enhanced nutritional supplement) three times a day at snack pass per RD recommendation." While this information was on the Medication Administration Record (MAR), there was no documentation to support how much, or if, the resident consumed these nutritional supplements.</p> <p>In an interview on 10/15/13 at 9:50 a.m., Staff B (Director of Nursing), stated it was "the nurse's responsibility (to ensure) that the 206 is being given... it's a doctors order and it's in the MAR...". Staff B elaborated it was the Nurse Aides responsibility to advise the nurse if the resident ate 50% or less of a meal and, "the Aide should offer an alternative (for the aide it would be an alternative food, like the alternate meal for lunch), for the nurse it might be a supplement that is in place." Staff B stated, "If there is no order (for a supplement), hopefully the LN (Licensed Nurse) will have a talk with the RCM (Resident Care Manager) to have the discussion (about nutritional supplements), the nurses can kick in a supplemental order while awaiting the physician order or eval(uation) by the RD (Registered Dietician), or interdisciplinary team/speech language pathologist."</p> <p>Additionally, observations on 10/11, 14 and 15/13 revealed unopened cans of Ensure at the</p>	F 325		

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F 325	Continued From page 36 resident's bedside. According to a Nutrition Data collection assessment dated 10/09/13 the resident, "dislikes Ensure." This RD assessment also indicated, "good to see wt stable" but failed to address the lack of wts for three months or consider that "poor to fair (intake)" might potentially contribute to a wt loss.  Failure to timely assess each resident's nutritional status, thoroughly evaluate and analyze the assessment information, develop and consistently implement pertinent approaches, monitor the effectiveness of interventions and revise them as necessary detracted from staff 's efforts to optimize the nutritional status for Resident #s 83 and 79.	F 325	F329 1. #166 resident behavior tracking reviewed and updated to reflect # of hrs slept and will be reviewed quarterly or as needed for effectiveness #83 Behavior monitoring reviewed and updated to reflect target behaviors based on record review and resident/family interview #135 Behavior monitoring reviewed and updated to reflect target behaviors based on record review and resident/family interview # 58 Resident psychotropic medications reviewed and behaviors updated based on record review and resident/family interview. Physician clarification of medication use as warranted. #154 Resident psychotropic medications reviewed and behaviors updated based on record review and resident/family interview. Physician clarification of medication use as warranted.	11/28/13
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 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 drugs receive gradual dose reductions, and	F 329	2. Audit of all active residents behavior monitoring and related diagnosis for psychotropic medications for accuracy.	

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F 329	<p>Continued From page 37</p> <p>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 ensure five of five residents (#s 166, 83, 135, 58 &amp; 154) reviewed for unnecessary medications and one of one residents (#20) reviewed for hospice were free of unnecessary medications related to adequate indications for use, use of non-pharmacological interventions prior to the use of an as needed psychotropic medication, consistent monitoring of the medication and lack of gradual dose reductions.</p> <p>In addition, medications were administered to Resident #166 in excess, outside of physician's orders, making them unnecessary medications.</p> <p>Findings include:</p> <p>CFR 483.20 (b) (i)(viii)(x)(xi)(xv), F-272, Resident Assessment CFR 483.20(d), (k)(1), F-279, Develop Comprehensive Care Plans</p> <p>RESIDENT #166 According to the 09/09/13 Minimum Data Set (MDS) assessment, Resident #166 admitted to the facility on 09/03/13 with care needs related to multiple diagnoses including depression and anxiety.</p>	F 329	<ol style="list-style-type: none"> <li>3. Social Services and Licensed nursing staff educated on BIMPRS and Psychotropic review forms and gradual dose reduction.</li> <li>4. Audits will be conducted monthly x 3 months based on MDS schedule on all active residents with orders for psychotropic medications.</li> <li>5. 11/28/13</li> <li>6. Executive Director or designee will ensure compliance.</li> </ol>	

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F 329	<p>Continued From page 38</p> <p>Review of the resident's record revealed an admission physician's order (PO), dated 09/03/13 for the anti-anxiety medication Clonazepam every night for "anxiety/sleep". Additionally, a PO, dated 09/24/13, directed staff to administer Melatonin every night for insomnia.</p> <p>Physician's orders from the resident's hospital stay, prior to admission to the facility, dated 08/09/13 indicated the [REDACTED] was for "sleep."</p> <p>A Mental Health progress note, dated 10/01/13 identified the resident with multiple concerns, including "insomnia". In an interview on 10/11/13 at 8:35 a.m., Resident #166 reported she took the [REDACTED] to help her sleep.</p> <p>The Behavior Intervention Monthly Flow Reports (BIMFRs) for September and October 2013 revealed staff monitored the resident for flat affect, racing thoughts and agitation, none of which were identified as having occurred since her admission. There was no indication staff monitored the resident's sleep, despite the administration of two medications nightly intended to help her sleep.</p> <p>In an interview on 10/11/13 at 8:02 a.m., Staff D stated there should be a monitor for sleep as the resident received two medications to help her sleep. She was unable to explain why staff had failed to monitor the resident's sleep patterns to determine the need for the addition of the [REDACTED] or to determine the medications effectiveness.</p> <p>In an interview on 10/11/13 at 8:59 a.m., Staff O,</p>	F 329	<p>F329 cont.</p> <ol style="list-style-type: none"> <li>#166 October MAR has been corrected to reflect correct Vitamin C and Zinc Sulfate orders.</li> <li>Audit all active resident MARs for reconciliation of physician orders with monthly recapitulation of physician orders and MARS</li> <li>Education for licensed nursing staff on recapitulation process.</li> <li>Audit of active residents MARs by recapitulation designated nurse every month. Nurse and/or pharmacy notified of transcription errors with warranted education. Monthly audits of MAR review x 3 with results presented at monthly PI committee for further recommendations for improvement</li> <li>11/28/13</li> <li>Director of Nursing or designee will ensure compliance.</li> </ol>	

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F 329	<p>Continued From page 39</p> <p>Social Service Director, stated she thought the [REDACTED] as for anxiety. She explained the medication was given at night as the resident "worried" when she went to bed. She also explained she did not think nursing monitored the resident's sleep patterns as the Melatonin was not a psychotropic drug, so "they don't think about it". She was unable to explain how the facility determined the ongoing need for, or effectiveness of, either medication without monitoring.</p> <p>In addition, review of a PO, dated 09/16/13, revealed staff were to "decrease" Vitamin C to 500 milligrams (mg) once a day for 30 days then discontinue and Zinc Sulfate was to be given once a day for 14 days then be discontinued. Review of the September and October Medication Administration Records (MARs) revealed staff transcribed the order incorrectly and administered the Vitamin C twice a day.</p> <p>In addition, the September MAR revealed staff administered the Zinc for 14 days and discontinued it on 09/25/13 as ordered. However, they began administering it again on 10/01/13 and gave it daily through 10/10/13, without a PO to do so.</p> <p>In an interview on 10/10/13 at 10:39 a.m., Staff D stated both the Vitamin C and Zinc were given in error and not in accordance with the PO. Both the Vitamin C and Zinc were given in excess, outside of physician's orders, making them unnecessary medications.</p> <p>RESIDENT #83 Record review revealed Resident #83 was started on an anti-depressant medication to treat depression in January 2013. There were no</p>	F 329			

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F 329	<p>Continued From page 40</p> <p>BIMFRs which identified what behaviors required the use of the medication for 01/13, 02/13 or 3/13. Failure to ensure behaviors were monitored detracted from the facility's ability to determine effectiveness of the medication.</p> <p>Further record review revealed no quarterly review of psychotropic medications from 02/13 to 08/13. In an interview on the morning of 10/16/13, when asked about the absence of reviews, Staff O indicated there had been administrative changes. Failure to periodically review for continued need of medications placed this resident at risk for use of an unnecessary drug.</p> <p>RESIDENT #135 Record review revealed Resident #135 admitted to the facility on [REDACTED]/13. She received the anti-psychotic [REDACTED] and the anti-depressant [REDACTED] for dementia with behavioral disturbances and depression.</p> <p>No behavior monitoring was present for the month of July 2013. The facility monitored the resident for suicidal ideation or thoughts and withdrawal from activities of interest from 08/10 through 08/31/13. Neither of these behaviors were documented as present and the facility stopped monitoring for any behaviors after 08/31/13, despite the resident's continued use of both the Seroquel and Remeron.</p> <p>In an interview on 10/14/13 at 11:41 a.m., Staff O stated Resident #135's "main behavior" was "calling out". She stated the facility should initiate behavior tracking upon admission when they identify the reasons a resident takes a medications. She reviewed the chart and stated "there should be more (behavior sheets), one for</p>	F 329		
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F 329	<p>Continued From page 41</p> <p>each month." She stated "For some reason she doesn't have one (ongoing behavior monitoring)." She explained staff should monitor the resident "for behaviors like poor appetite, self isolation, calling out." She was unable to explain why that was not done.</p> <p>In an interview on 10/14/13 at 12:22 p.m., Staff J, nurse, stated for residents who received an anti-psychotic staff would monitor behaviors on a flow sheet provided by social services. Staff J reviewed the MAR and stated staff should be, but were not, monitoring behaviors for this resident.</p> <p><b>RESIDENT #58</b> Resident #58 was admitted on 04/10/13 with physician's orders for the anti-depressants Cymbalta 60 mg daily and Nortriptyline HCL 25 mg daily, both for pain management.</p> <p>According to the 04/10/13 psychoactive medication informed consent for the [REDACTED] the resident had a diagnosis and history of "depressive disorder and chronic ulcer leading to pain and low mood", with the expected benefits of the medication to be increased mood and decreased pain.</p> <p>According to the 04/10/13 Psychoactive medication informed consent for [REDACTED] the "res(ident) says she has been taking this med for about 15 years for chronic left periorbital pain, chronic pain". The expected benefits included decreased pain.</p> <p>A 04/13/13 Social Service assessment indicated the resident experienced "Depression (as evidenced by) flat affect decreased motivation and pain."</p>	F 329		

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F 329	<p>Continued From page 42</p> <p>The 04/17/13 Admission MDS listed a diagnosis of depression, with an assessed mood score of 0 indicating a lack of signs or symptoms of depression. The 04/17/13 Psychotropic Drug Use Care Area Assessment described the problem as "Resident admitted with dx of chronic non healing abdominal ulcer... depression... chronic pain." The plan included, "...Psych meds review qtrly (quarterly) and prn (as needed)."</p> <p>The 07/11/13 Quarterly MDS listed diagnoses of chronic pain and depression, indicated the resident experienced pain occasionally, was assessed with a mood score of 0 indicating a lack of signs or symptoms of depression, and received daily anti-depressant and pain medications.</p> <p>The 10/07/13 Psychotropic Medication Care Plan indicated the resident received the anti-depressants for depression, and was at risk for side effects and ineffectiveness related to pain management. Approaches included "review the continued need for drug qtrly and prn and document prn."</p> <p>In an interview on 10/14/13 at 7:30 a.m. Staff O said of the anti-depressant medications, "she takes for pain, she's had this mood for a long time... flat affect, slowly participating more...". Staff O indicated the Target Behaviors being monitored by staff were low mood related to pain and flat affect.</p> <p>Review of the August, September and October 2013 BIMFRs revealed a lack of exhibited target behaviors on all days, all shifts.</p> <p>The Psychoactive Medication Review &amp; Behavior</p>	F 329			

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F 329	<p>Continued From page 43</p> <p>Monitoring Review (PMRBMR) was dated as initiated 04/16/13 with the listed medications, doses and start dates. No further review or analysis of the targeted behaviors were documented. In an interview on 10/15/13 at 10:43 a.m. Staff O said the intent was for the monitoring of the behavior tracking to be on the back of the form however it was not done.</p> <p>In an interview on 10/15/13 at 10:31 a.m. Staff B said psychoactive medications were reviewed on a quarterly basis, working with pharmacist recommendations for gradual dose reductions (GDR) and documented on a form by Social Services.</p> <p>In an interview on 10/14/13 at 7:30 a.m. when asked if GDRs were considered due to the lack of target behaviors, Staff O reviewed the pharmacy documents and commented "she doesn't have a recommendation for a GDR." In addition, Staff O indicated she did not see a possible GDR addressed in Mental Health meeting notes, or on the PMRBMR form. Staff O was unable to provide documentation the psychoactive medications had been monitored since admission or that there was an assessment for their continued need. In addition, failure to clearly identify the reasons for the medications, whether pain, depression, or both, placed this resident at risk to receive unnecessary medications.</p> <p><b>RESIDENT #154</b> According to the 07/18/13 MDS, Resident #154 was assessed with diagnoses including anxiety disorder and schizophrenia. Review of MARs, BIMFRs and progress notes revealed the resident received as needed Ativan (anti-anxiety medication) without benefit of non drug</p>	F 329			

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F 329	Continued From page 44 interventions on 10/08/13. Additionally, the BIMFRs did not reflect the resident exhibited behaviors that required the use of anti-anxiety medications on the shift it was administered. Staff Q reviewed the record on 10/14/13 and confirmed these findings.  RESIDENT #20 Record review revealed Resident #20 was admitted to the facility with multiple complex care needs. Review of admission records revealed the resident received the anti-psychotic medication Seroquel. According to Target Behavior documents, facility staff monitored the behaviors of "combative" and "agitation" related to "psychosis" for the use of the [REDACTED]  Upon conferring with the resident's physician on 10/10/13, Staff D indicated the resident received the Seroquel for "severe depression" and not psychosis. Failure to accurately identify indication for use of an antipsychotic medication detracts from the facility's ability to determine it's effectiveness.	F 329	F363 1. #11 was not adversely affected by this failed practice 2. No other residents affected by this failed practice 3. Dietary department in-serviced on portion size, accuracy of menu and following tray cards for each resident. 4. Will conduct random audits of resident meal trays for accuracy per the dietary order by registered dietician. 5. 11/28/13 6. Executive Director or designee to ensure compliance.	11/28/13
F 363 SS=D	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED  Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.  This REQUIREMENT is not met as evidenced by:	F 363		

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F 363	<p>Continued From page 45</p> <p>Based on observation, interview and record review it was determined that the facility failed to follow the planned menu. Failure to serve the correct portion sizes for residents who required a large portion, as well as failure to serve the starch as identified on the menu placed residents at risk for less than adequate nutritional intake or dissatisfaction with their meal.</p> <p>Findings include:</p> <p>Review of the planned menu for the lunch meal on 10/10/13 revealed the main entree was identified as a "seafood platter". Residents with an order for a regular portion size were to receive a two ounce portion of the entree. The menu directed staff to provide one and one half a serving of the entree for residents who required "large portions".</p> <p>Throughout the tray service, Staff Y was observed to serve one portion of fish and two shrimp to residents who required a regular portion size. For residents whose diet ordered either large portions or large protein, Staff Y was observed to serve one portion of fish and three shrimp. In an interview at 12:25 p.m., after the 600 unit, main dining room and 100 unit had been served, Staff Y stated she was "not really sure" about the large portions for the seafood platter. She explained that as the regular portions received two shrimp, she thought one and one half the entree was three shrimp. She was unable to explain why residents did not receive an extra half a serving of fish.</p> <p>In an interview at 12:30 p.m., Staff Z, Food Service Supervisor, stated residents who required either a large portion or large protein diet should</p>	F 363		
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F 363	Continued From page 46 have received one and one half times the fish as that was the "main protein of the meal". He explained the menu was new to the rotation and staff had not previously served it. He stated he should have reviewed the serving sizes prior to meal service.  Additionally, the planned menu identified a "baked sweet potato half" for the alternate meal. Staff were observed to prepare baked sweet potato fries instead. In an interview at 12:33 p.m., Staff Z stated baked sweet potatoes were "labor intensive" and he thought residents liked the fries better so he substituted them. He stated they were "basically the same thing." He acknowledged he had not revised the menu to reflect the change even though he had planned for the fries.  During tray line, Resident #11 was to receive a puree alternate meal. Staff had not pureed the beets and so she did not receive any vegetable. Staff Z stated staff should have stopped tray line to puree beets, even if it was for only one person. He stated staff reviewed the tray cards prior to meal service, so they would know what they needed to have prepared. He acknowledged the menu was not followed for this resident.	F 363	F425 1. #166 [REDACTED] Vit. C and Zinc Sulfate orders corrected on MAR and physician order #65 [REDACTED] order has been clarified and/or corrected in both physician order and MAR. #83 October MAR has been corrected to reflect monitoring of Apical pulse intended by physician #35 Order was clarified immediately 2. Review of all active resident MARS for reconciliation of P.O.s against MARS and monthly recaps of P.O.s by designated LN. 3. L.N. training on: a) proper order transcription technique at point of service and during monthly recaps. b) What constitutes a complete order Designated personnel for review of monthly physician order recapitulation. Discovery of near miss errors at time of monthly P.O. recap reviews reported to DNS and pharmacy for PI follow up.	11/28/13	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH  The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general	F 425			

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F 425	<p>Continued From page 47 supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to ensure pharmaceutical services which assured the accurate dispensing and administration of all drugs to meet the needs of each resident. Failure to ensure the process for clarifying and recapitulating physician's orders was accurate placed Resident #s 166, 85 and 83 at risk for medication errors, lack of monitoring, and resulted in medication errors, and at least one resident receiving unnecessary medications. Failure to ensure physician's orders clearly reflected how staff were to administer Intravenous medications placed Resident #35 at risk for medication errors.</p> <p>Findings include:  RESIDENT #166 Review of Resident #166's chart revealed a physician's order (PO), dated 09/16/13 that</p>	F 425	<p>4. Random audits of MAR:MAR, MAR:P.O, P.O to monthly physician orders recapitulation weekly x 4 weeks then monthly x 3 months. Results will be reviewed of MAR audits and near miss error at monthly PI meeting for further recommendations.</p> <p>5. 11/28/13</p> <p>6. Director of nursing or designee to ensure compliance.</p>	
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F 425	<p>Continued From page 48</p> <p>directed staff to decrease the Vitamin C to 500 milligrams (mg) once a day for 30 days then discontinue it and to give Zinc Sulfate 220 mg for 14 days then discontinue it.</p> <p>Review of the 09/13 Medication Administration Record (MAR) revealed staff failed to accurately transcribe the Vitamin C order. They added the stop date of 10/11/13 (30 days after the 09/16/13 order), however they failed to change the administration of the Vitamin C from twice a day to once a day. Additionally, staff followed the PO to stop the Zinc on 09/25/13, after 14 days, however the 10/13 MAR included the Zinc to be given with instructions for "30 days". Staff administered the Zinc from 10/01 through 10/10/13, as staff failed to notice the error in the order.</p> <p>In an interview on 10/10/13 at 10:39 a.m., Staff D, Resident Care Manager (RCM), stated the Vitamin C and Zinc were given in error and not in accordance with the PO. She acknowledged the orders were not transcribed accurately and that staff failed to notice the errors during monthly recapitulations.</p> <p>In addition, the admission PO, dated 09/03/13, directed staff to give [REDACTED] daily at bedtime for anxiety and sleep. This order was changed to "daily at bedtime as needed" on the October POs compiled by the pharmacy. Facility staff signed the orders were reviewed on 10/01/13 and the physician signed the orders 10/05/13. The as needed order was transcribed to the October 2013 MAR. Staff marked out the "as needed" direction on the MAR and proceeded to give the Clonazepam nightly, however they failed to obtain a PO changing the order back to routinely.</p>	F 425		

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F 425	<p>Continued From page 49</p> <p>In an interview on 10/11/13 at 8:02 a.m., Staff D stated staff should have gotten a physician's order to change the [REDACTED] from as needed back to routine. She stated it appeared the pharmacy incorrectly wrote the order to "as needed" and the nurse missed it during the monthly recapitulation and the physician signed it, making it a valid order. She said staff must have then caught it on the MAR and changed it back to routine, but failed to get a PO to do so.</p> <p><b>RESIDENT #85</b> During medication pass observation on 10/10/13 at 1:51 p.m. Staff F was observed to prepare and administer Resident #85 one 10 mg pill of [REDACTED] the October MAR listed the 09/26/13 PO for [REDACTED] IR 5 mg, give 2 tabs every six hours as needed.</p> <p>Review of the resident's record revealed a 09/27/13 Pharmacy "Resident Profile" which indicated the resident was to receive [REDACTED] 10 mg IR tablet give 2 tablets by mouth every 6 hours as needed for pain." This would be a dose of 20 mg rather than the 10 mg administered.</p> <p>In an interview on 10/09/13 at 11:05 a.m. Staff AA stated it appeared to be a "pharmacist error" and that the last order the facility had was for 10 mg total. She stated staff should have obtained a clarification order due to the inaccurate transcription.</p> <p><b>RESIDENT #83</b> According to telephone orders dated 09/06/13, staff were do do "daily ap (apical pulses) x 30 days then weekly. notify md if ap &lt;60 or &gt; 100 in</p>	F 425		
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F 425	<p>Continued From page 50</p> <p>2 consecutive readings." Staff did this from 09/11 to the end of September but the order wasn't carried over to the October MAR. This was confirmed by Staff E and J on 10/11/13 at 11:29 a.m. Failure to ensure a system by which the end of month recapitulation of POs was accurate resulted in Resident #83 not getting the monitoring intended by the physician.</p> <p><b>MEDICATION PASS</b></p> <p>Observation of medication pass on 10/08/13 revealed Staff Q prepare and administer Intravenous (IV) medication to Resident #35. According to POs, staff were to administer 50 mgs of diphenhydramine over two minutes IV push. Staff Q was observed to dilute the diphenhydramine in nine ccs (cubic centimeters) of normal saline (ns) prior to administration. There were no directions or consistent instructions as to how much, if any, dilutant should be used in the administration of this drug.</p> <p>In an interview on 10/08/13, Staff Q was asked how she knew to dilute the medication. Staff Q stated, "the RCM told me... we had an inservice and I was told that I should (dilute with ns)...". When asked how staff would know to dilute with nine ccs ns, Staff Q stated, "I understand your question". Record review revealed no clear instructions to dilute the diphenhydramine or how much ns with which to dilute.</p> <p>In an interview on 10/15/13 at 9:51 a.m., Staff B (Director of Nursing) stated, "we should have clear orders which delineate what is to be done...". Failure to ensure POs were clear detracted from staff's ability to administer medication in a consistent manner and had the potential to contaminate the medication through</p>	F 425		

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F 425	Continued From page 51 additional handling.	F 425	F431	11/29/13
F 431 SS=D	<p><b>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</b></p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p>	F 431	<ol style="list-style-type: none"> <li>1. No residents were negatively affected by this failed practice.</li> <li>2. Review of all medication carts, e-kits inclusive of IV fluids and refrigerators with disposal of medication as indicated.</li> <li>3. L.N. education on pharmaceutical and biological storage and labeling.</li> <li>4. Audit of medication carts, refrigerators, and medication room weekly with destruction of any expired medications x 4 weeks than monthly x 3 months. Weekly cart cleaning ongoing. Results of drug storage audits to be reviewed at monthly PI committee for further recommendations.</li> <li>5. 11-28-13</li> <li>6. Director of Nursing or designee to ensure compliance.</li> </ol>	

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F 431	<p>Continued From page 52</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure medications were labeled, stored, dated and discarded according to facility policy and pharmacy standards. Failure to label, store, date and discard medications as indicated, on five of five medication carts, placed residents at risk to receive medications that were expired.</p> <p>Findings include:</p> <p>100 UNIT Observation during initial rounds on 10/08/13 at 9:05 a.m. revealed the 100 medication cart contained insulin for Resident #140 which was dated as expired on 09/05/13, an [REDACTED] for Resident #85 which was open and undated, and one insulin which was open and undated. Observation of the 100 medication cart on 10/14/13 at 12:25 p.m. revealed a vial of insulin for Resident #169 which was dated as open on 09/10/13 and expired on 10/10/13. This information was confirmed with Staff Q.</p> <p>200/400 UNIT In an interview on 10/08/13 at 9:30 a.m., Staff D, stated "We date medications as we open them if a medication has expired; we usually send it back to the pharmacy or destroy it."</p> <p>Observation of the 400 medication cart on 10/11/13 revealed several bottles of artificial tears which expired on 10/10/13. According to Staff M, who was assigned to the cart on 10/11/13, there were six nurses assigned to work the medication cart, and they were all equally responsible for</p>	F 431			

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F 431	<p>Continued From page 53</p> <p>ensuring expired medications were discarded. In addition, medication carts on the 200 and 400 halls were both found to have unidentifiable dried substances on bottles of liquid medications and several loose pills were observed in the drawers on both carts. A brownish colored substance was observed along the tracks of both medication carts. Staff F, stated the medication carts were cleaned monthly depending on how dirty they were.</p> <p>Additionally, several medications were observed to either have no open date or had expired on the 200 hall medication cart. Observed without opened dates were a levemir (insulin) pen, Nystatin (oral) medication and Orajel (tooth ache ointment). Resident #20 had oxcarbazepine liquid on which the label was torn and unreadable. Multiple medications were observed in the cart for a resident who no longer lived on the hall. According to Staff D, the resident moved about a month ago and her medications did not get moved with her. Similar findings were observed on the 400 hall medication cart in which the lower drawer contained several medications in a plastic basket without names or labels. In an interview Staff G, replied "I guess it's the treatment basket, but I'm not sure, I never look in the basket, so I don't know who the medications belong to, but I think it's house supply."</p> <p>300 UNIT Observation of the 300 medication cart on 10/08/13 at 9:36 a.m. revealed three bottles of artificial tears all open and dated as expired on 10/01/13. A bottle of Atropine drops for Resident #83 which were open and not dated, eye drops for Resident #1 which were open and not dated, a nasal spray for Resident #1 which was stored</p>	F 431		

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F 431	Continued From page 54 without its cap, and insulin for Resident #135 which was dated as expired on 09/21/13. A bottle of open and undated lidocaine solution was identified for Resident #161, who Staff J stated had, "been gone a couple of months."  600 UNIT Review of the 600 medication cart on 10/08/13 at 9:45 a.m. revealed the following: a specimen cup with Resident #48's first name written on the outside held a vial of Latanoprost marked as "opened 8/30; exp 9/30", along with a vial of Timolol "open 8/30 expire 9/30"; a vial of Latanoprost for Resident #11 marked as "open 9/3, exp 10/3"; a vial of Hemocult that was half empty with no open date and a manufacturer's expiration date of 08/13; a vial of Refresh for Resident #11 with an unreadable open date; and a vial of [REDACTED] for Resident #80, delivered 08/23/13 with no open date. According to Staff U, nurse, at 9:24 a.m., the medication was only used for "ten days" and was not being used anymore. She stated it should have been discarded. Staff U also acknowledged the above medications on the 600 cart, should have been, but were not discarded when expired.	F 431	F460 1. #135, #74, # 118 Privacy curtain was replaced to ensure full privacy. 2. All rooms have been checked to ensure privacy curtains are functional and replaced as needed. 3. Rooms will be audited weekly x4 weeks than monthly x 3 months to ensure functionality and length of privacy curtains meet the privacy and dignity needs 4. Results of audits will be reviewed at monthly PI for further recommendations for improvement. 5. 11/28/13 6. Executive Director or Designee will ensure compliance.	11/28/13
F 460 SS=D	483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY  Bedrooms must be designed or equipped to assure full visual privacy for each resident.  In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains.	F 460		

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F 460	<p>Continued From page 55</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure full visual privacy for residents due to a failure to provide curtains which extended fully around each resident's beds.</p> <p>Findings include:</p> <p><b>RESIDENT #135</b> On 10/14/13 at 7:10 a.m. a dressing change to Resident #135's <span style="background-color: black; color: black;">[REDACTED]</span> area was being done. Staff J conducted the dressing change while Staff P assisted. During the dressing change it was observed that the privacy curtain did not go completely around the resident's bed to provide full visual privacy. Resident #135 was located in the first bed upon entering the room. While curtain tracks were present, the privacy curtain was not long enough to extend the length of the tracks. At the head of the bed there was approximately two feet of open space that looked directly in on the next resident's bed. At the foot of the bed on the opposite corner there was approximately one foot of open space that had a direct line of sight to the door. The resident was lying on her right side, buttocks exposed towards the door.</p> <p>At 7:24 a.m. Staff T knocked and entered Resident #135's room. Due to the curtain not providing full privacy, Staff T was able to see that the resident was on her side and care was being given. Staff T quickly exited the room. When asked about the short length of the curtain both Staff J and P acknowledged that the curtain</p>	F 460		

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F 460	Continued From page 56 wasn't long enough, but denied that it was a problem.  Similar findings were observed on rounds of multi resident rooms conducted on 10/15/13 at 8:30 a.m. The privacy curtains observed for rooms 102-1, 102-2, 303-1, 303-2, 304-2, 312-1, 312-2, 406-2, 412-1 and 414-3 were not long enough to provide full privacy to either resident. Resident #74 in 406-2 acknowledged the curtain was too short and commented, "I change in the bathroom."  In addition, the privacy curtains for 409-1 and 414-1 were long enough but could not be opened due to an empty clip stuck in the track. The privacy curtain for 401-2 was caught in the clips for the curtain of 401-3, so it could not be closed around the resident. Resident #118 in bed 409-2 said, "They close the door and they close the curtains as much as they can."  In an interview on 10/15/13 at 9:28 a.m. Staff K said each room has different sizes of privacy curtains and when housekeeping staff hang them they need to make sure they are long enough.	F 460	F514 1. #83 POA documentation has been accessed an in record. POA contacted to sign consents for pnuemovac/influenza vaccinations. Consult records were placed in chart. Retrieval and correct placement of other residents podiatry consult. #82 Resident experienced no harm from this failed practice. #33,#112 Resident experienced no harm from this failed practice. 2. Audit of active residents charts reviewed for reconciliation of actual current level of care and provision of services. 3. Education provided to LNs, HIM, SW and CNAs: a. congruency between records b. congruency between cognitive status and ability to record signature for consents.	11/28/13	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient	F 514			

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F 514	<p>Continued From page 57</p> <p>information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to ensure clinical records were maintained on each resident that were complete and accurate. The facility failed to ensure end of month recapitulations reflected the residents assessed needs; power of attorney documents were present; staff accurately documented care provided; staff accurately documented diagnoses and behavior monitoring; and that resident records contained only records pertaining to that resident. Failure to ensure clinical records were accurate and complete prevented staff from ensuring resident's needs were met.</p> <p>Findings include:</p> <p>Refer to: CFR 483.10(f)(2), F166, Facility Resolve Grievances CFR 483.20 (b) (i)(viii)(x)(xi)(xv), F-272, Resident Assessment CFR 483.20(d), (k)(1), F-279, Develop Comprehensive Care Plans CFR 483.25(l)(1), F-329, Unnecessary Medications CFR 483.60(a),(b), F-425, Pharmaceutical Svc - Accurate Procedures</p> <p>RESIDENT #20</p>	F 514	<ul style="list-style-type: none"> <li>c. Availability of records promptly after consults</li> <li>d. Proper documentation indicating actual care provided inclusive of refusals</li> <li>e. explicitness for room change necessity</li> </ul> <p>4. Random monthly chart audits by RCMs for consolidation and validation of current level of care and provision of services x 3 months. Results of audits to be reviewed at monthly PI committee meeting for further recommendations for improvement</p> <p>5. 11/28/13</p> <p>6. Director of Nursing or designee to ensure compliance.</p>	

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F 514	<p>Continued From page 58</p> <p>Review of Resident #20's record revealed the hospice documents of three other patients that were not Resident #20. There was insufficient documentation to support this resident experienced psychosis, yet staff documented in the Care Plan, on target behavior records and in the Minimum Data Set (MDS) the resident had psychosis. There was no documentation to support the resident received anti-psychotic medication as an adjuvant to anti-depressant therapy.</p> <p><b>RESIDENT #83</b> Staff failed to ensure physician ordered pulse monitoring was transferred from September's records to October's records, thus required documentation was not provided.</p> <p>In an interview on 10/14/13 at 12:00 p.m., Staff O indicated Resident #83 had a Power of Attorney (POA). Record review revealed no documents to support this. In an interview on 10/15/13 at 9:44 a.m., Staff O confirmed the resident had a POA but there was no evidence of this in the record.</p> <p>According to the 08/26/13 MDS, the resident was assessed as "severely impaired" for cognitive decision making, "never/rarely made decisions" and "rarely never understood". Record review revealed Resident #83's flu and pneumovac consent forms had a scrawled signature under "Resident" signature. Staff O indicated that if the resident had a POA, he should not sign his own consents.</p> <p>Additionally, there was no evidence in the record the resident had received podiatry services since 09/24/12. Upon request, the podiatrist provided documentation the resident was seen on</p>	F 514		
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F 514	<p>Continued From page 59 03/12/13 and 06/10/13.</p> <p>Staff J documented nail care was provided for Resident #83 on 10/11/13. In an interview on 10/14/13, Staff J indicated nail care was not provided as the resident refused. Staff J stated the refusal should have been documented.</p> <p>A podiatry consult/document which belonged to another resident was identified in Resident #83's record.</p> <p><b>RESIDENT #82</b> Record review revealed Resident #82 was to have her pain assessed during each of the three shifts per day using the pain scale (Scale of 0-10, "0" meaning no pain and "10" meaning the most pain possible). The MAR (Medication Administration Record) indicated in the month of September the resident had pain less than ten times out of the 90 times it was assessed. However, review of the Pain Flow Sheet (PFS) for September had conflicting information. The PFS was used by the facility to track PRN (as needed) pain medication administration along with non-drug interventions attempted. The September PFS revealed a total of 13 episodes of pain resulting in the administration of the resident's PRN pain medication. Reassessment of the resident's pain never revealed the resident's pain was a 0/10 on the September PFS. Per the MAR the resident reported no pain (0/10) during all three shifts on 09/12/13, 09/13/13, 09/14/13, 09/20/13, 09/22/13, 09/23/13, 09/24/13 and 09/25/13. Contrary to that, all of these dates on the September PFS revealed the resident received PRN pain medication due to pain ratings of 6-7/10.</p>	F 514		

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F 514	<p>Continued From page 60</p> <p>On 10/14/13 at 12:21 p.m. Staff J was asked about the differing information on the MAR verses the PFS. Staff J stated "They should match.... supposed to anyways."</p> <p>On 10/15/13 at 8:45 a.m. Staff G confirmed the pain ratings on the MAR and PFS should match.</p> <p>Further record review revealed similar findings for the October MAR and October PFS for this resident.</p> <p><b>ROOM CHANGE NOTICE</b> A notification of room change form was located in Resident #33's chart. It indicated the resident was transferred to a new room on 09/10/13 for "consolidation of care". In an interview on 10/11/13, Staff O stated the room change was due to a change in the resident's pay source. She stated the form should have clearly identified the reason for the room change.</p> <p>Similar observations were made in the record of Resident #112 for whom three room change notifications, dated 10/01/12, 10/04/12, and 10/12/12, were present all with the reason for the room changes identified as "consolidation of care".</p>	F 514		

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