

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

1196
PRINTED: 08/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505306	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/09/2013
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF PORT TOWNSEND	STREET ADDRESS, CITY, STATE, ZIP CODE 751 KEARNEY STREET PORT TOWNSEND, WA 98368
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Life Care Center of Port Townsend on 08/05/13, 08/06/13, 08/07/13, 08/08/13 and 08/09/13. A sample of 31 residents was selected from a census of 52. The sample included 25 current residents and the records of 6 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>██████████ MSW ██████████ RN, MN ██████████ BSS ██████████ MS</p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging and Long Term Support Administration Residential Care Services District 3, Units A, C & D P.O. Box 45819 Tumwater, Washington 98501</p> <p>Telephone: 360.664.8429 Fax: 360.664.8451</p> <p><i>John P. [Signature]</i> 8-15-13 Residential Care Services Date</p>	F 000	<p>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.</p> <p>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.</p>	
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RECEIVED
AUG 27 2013
DSHS/ADSA/RCS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Executive Director	(X6) DATE 8/20/13
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156 SS=D	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal</p>	F 156	<p>F156</p> <ol style="list-style-type: none"> Resident #79 and the representative have been notified of Medicare coverage. Others with changes in Medicare benefits were audited and residents or Responsible parties were notified of benefit changes. Staff educated that the resident or Responsible party must be fully informed of Medicare benefit changes. A monitoring system was incorporated into the daily IDT meeting to ensure Medicare benefit notification is provided. The system will be audited in PI to ensure effectiveness and sustainability. Date of correction 9.9.13. The Executive Director will ensure ongoing compliance. 	

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F 156	Continued From page 2 funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.	F 156		

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F 156	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure Medicare benefit information was provided to the resident/representative for 1 of 3 (#79) current sampled residents reviewed for notification of benefits. The failure placed residents at risk of not receiving necessary care and services and understanding benefits and appeal rights.</p> <p>Findings include:</p> <p>Resident #79 was admitted to the facility on [REDACTED]/13 with diagnoses including dementia and [REDACTED]. The resident's Minimum Data Set, an assessment tool, dated 04/11/13, indicated severe cognitive impairment.</p> <p>On 08/09/13 the facility provided documentation to the surveyor the notification Resident #79 would not be covered by Medicare after 04/14/13. The documentation indicated a telephone message had been left for the beneficiary's representative on 04/11/13. The document did not have a representative beneficiary signature to indicate proper notification had been received.</p> <p>On 08/09/13 at 11:50 a.m., the Executive Director (ED) stated a message had been left for the representative. The ED could not provide documentation the information had been received. Chart notes did not provide documentation the beneficiary's representative had received notification of benefits ending.</p>	F 156		

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F 164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure personal privacy and confidentiality were ensured for 2 of 4 (#75 & 102) current sampled residents reviewed for privacy. This failure violated personal privacy of residents.</p>	F 164	<p>F164</p> <ol style="list-style-type: none"> Resident #102 no longer resides at the facility. Resident #75 was assessed with no negative findings. Residents' care plans have been revised and updated. Resident #75 was assessed with no negative findings. Residents' care plan has been revised and updated. All female residents have been reviewed for female caregiver preferences. All Staff educated on privacy and confidentiality. 	

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F 164	<p>Continued From page 5</p> <p>Findings Include:</p> <p>1) Resident #75 was readmitted to the facility on [REDACTED] 13 with diagnoses including [REDACTED]. The resident's Minimum Data Set (MDS), an assessment tool, dated 05/04/13, indicated the resident was able to make needs known.</p> <p>On 08/06/13 at 3:42 p.m., Resident #75 stated, "I want my skin checks done by a female nurse." She stated a male nurse completed her skin check during her last shower. The resident said, "It was distasteful. I got upset." Resident #75 stated, "I told him to get out of here, I want a woman."</p> <p>On 08/08/13 at 1:30 p.m., Resident #75 stated she had requested the facility get the female nurse to conduct the skin assessment. After she requested the female nurse, the male nurse completed the skin assessment. The resident stated, "That sure was degrading. I felt like I didn't matter."</p> <p>At 1:45 p.m. the Resident #75's care directive was reviewed. The directive stated the resident prefers female caregivers.</p> <p>At 1:50 p.m., Licensed Nurse (LN) B stated, "She doesn't like male care givers."</p> <p>At 4:05 p.m., LN A confirmed he provided direct nursing care on 08/01/13 and had completed the skin assessment for Resident #75. When asked if the resident had said to him, "Get out of here, I want a woman," LN A confirmed the resident had said that.</p>	F 164	<p>4. Residents will be encouraged at the time of admission and during 72 hour post admission care conferences on reporting concerns and complaints.</p> <p>Satisfaction surveys will be conducted on an ongoing basis for all residents to ensure privacy and confidentiality.</p> <p>5. Date of compliance 9.9.13</p> <p>6. The Executive Director is responsible for ongoing compliance.</p>		

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F 164	<p>Continued From page 6</p> <p>On 08/09/13 at 9:25 a.m., the Director of Nursing Services (DNS) stated, "If a female resident did not want a male nurse to do a skin check, I would expect the male nurse not do the skin check." When asked specifically about Resident #75's concern regarding the skin check on 08/01/13, the DNS stated, "He should have backed out of the room and got a female nurse."</p> <p>2) Resident #102 was admitted to the facility on [REDACTED]/13 due to a [REDACTED] and need for rehabilitation. The resident's MDS, dated 06/28/13, indicated the resident is cognitively intact and able to make needs known.</p> <p>On 08/05/13 at 5:17 p.m., Resident #102 stated her injury was a workplace injury and was to be covered under Labor and Industries Insurance. Resident #102 stated she had been approached by facility staff on three different occasions regarding insurance coverage questions. Resident #102 stated the last time she was approached, three staff came into her room and had a detailed conversation about her medical coverage and benefits in the presence of a visitor.</p> <p>The resident stated she later approached the Admission Manager (AM) to inform her that she had been uncomfortable having private information discussed in front of her friend.</p> <p>On 08/08/13 at 5:05 p.m., the AM stated she and two other staff had gone to the resident's room to discuss insurance issues. The AM confirmed the conversation took place in the presence of the resident's friend. The AM stated, "We did not ask if it was ok to speak about private information in front of the friend and she did not tell us not to."</p>	F 164		

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F 164	Continued From page 7 The AM stated, "I apologized and said it wouldn't happen again. On 08/09/13 at 11:06 a.m., The Executive Director stated if staff need to speak to a resident and they have a friend present, we would need to ask if it was ok to speak in front of the friend or come back later. Page 12, Section 9 of the Resident Admission Agreement stated: The Facility keeps a record of the health care services the Facility provides the Resident. Information contained in the Resident's records is confidential, except as required to be disclosed under applicable law.	F 164			
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to promptly resolve grievances for 1 of 14 current sampled residents (#54) reviewed for missing property when facility staff failed to report the missing property when notified by the resident's family. This failure violated the resident's right to prompt resolution of grievances. Findings include:	F 166	F166 1. Resident #54 assessed and reported the grievance has been resolved to her Responsible parties satisfaction. Resident #54 no longer resides at the facility.		

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F 166	<p>Continued From page 8</p> <p>Resident #54 was admitted to the facility on [REDACTED] 13 with diagnoses including [REDACTED] disease, [REDACTED]</p> <p>The resident's Minimum Data Set, an assessment tool, dated 06/24/13, indicated the resident was severely cognitively impaired and required extensive assistance with all Activities of Daily Living.</p> <p>On 08/05/13 at 3:21 p.m., the Executive Director (ED) stated she was the point of contact for grievances and their resolutions.</p> <p>On 08/06/13 at 2:48 p.m., the resident's family member stated two (2) weeks ago he reported to the facility's receptionist and housekeeping supervisor the resident had a blanket missing. The family member stated there had not been any follow-up with facility staff about the status of the missing blanket.</p> <p>On 08/08/13 at 2:16 p.m., Licensed Nurse (LN) C stated she had heard the resident had a missing blanket a few weeks back. LN C was not sure what happened about it.</p> <p>Record review of the Grievance Log for May, June, July and August 2013 showed there was not an entry for Resident #54 regarding a missing blanket.</p> <p>At 4:33 p.m., the ED stated she was not aware of a missing blanket for Resident #54. The ED said a concern card should have been filled out by staff after they heard of Resident #54's missing blanket.</p>	F 166	<ol style="list-style-type: none"> 2. Resident council informed and educated on grievance resolution process. <p>There were no further reports of unresolved grievances.</p> <p>All staff were educated about requirements of F166.</p> 3. Residents will be encouraged at the time of admission and during 72 hour post admission care conferences on reporting complaints and the grievance resolution process. <p>Satisfaction surveys will be conducted on an ongoing basis for all residents to ensure grievance resolution. Results will be reviewed in PI for effectiveness and sustainability.</p> 4. Date of correction 9.9.13. 5. The Executive Director will ensure ongoing compliance. 	
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F 166	Continued From page 9 The ED said the facility policy was for staff to have a concern card filled out when they hear about any concerns from a resident or their family. The ED indicated if the facility is unable to locate a resident's missing item, the facility would replace the item at no cost to the resident.	F 166		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported	F 225	F225 1. Resident #58 was assessed with no negative findings. Investigation completed and state hotline notified. Care plan revised and updated. 2. Other residents interviewed to rule out abuse/neglect. Agency NAC no longer works at the facility. 3. All staff educated on requirements of F225.	

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F 225	<p>Continued From page 10</p> <p>to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to operationalize policies and procedures for abuse prohibition related to the thorough investigation and reporting of incidents of potential mistreatment, abuse/neglect for 1 of 4 current sampled residents (#58) reviewed for incident investigations. This failure placed residents at risk for abuse/neglect.</p> <p>Findings include:</p> <p>Resident #58 was admitted to the facility on 12/17/2012 with multiple diagnoses to include [REDACTED] The Minimum Data Set (MDS), an assessment tool, dated 5/11/13, identified the resident required extensive assist of two persons for bed mobility, transfers, and personal hygiene. The MDS, dated 5/11/13, also identified the resident was cognitively intact.</p> <p>On 8/8/13 at 4:30 p.m., Resident #58 reported a nursing assistant (NA) from the agency came in her room and said she needed to be changed in the middle of the night. The resident reported the NA was in a hurry and pulled the brief off in a rush, and after, just pulled the covers over her. Resident #58 reported the next morning she</p>	F 225	<p>4. All allegations and grievances will be reviewed daily by IDT to ensure thorough investigation and reporting of incidents.</p> <p>Weekend nurse managers/MOD will identify potential allegations and contact ED/DNS as needed.</p> <p>Staff education related to F225 requirements will be provided quarterly.</p> <p>All incidents will be audited for thorough investigation x 4 weeks and then monthly.</p> <p>5 The Director of Nursing and Executive Director will ensure ongoing compliance.</p> <p>6 Date of Correction 9.9.13.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505306	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/09/2013
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF PORT TOWNSEND			STREET ADDRESS, CITY, STATE, ZIP CODE 751 KEARNEY STREET PORT TOWNSEND, WA 98368		
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F 225	<p>Continued From page 11</p> <p>noticed a red mark on her skin where the brief had been pulled. The resident stated it was not the tender love and care she normally received from the staff, and reported she is not one to complain.</p> <p>When asked if the incident had been reported, the resident stated she told NA X. The resident stated NA X told her that sounded like something she should report to the director of nursing services (DNS). When asked if she reported the incident to the DNS, the resident responded, "Yes, I did."</p> <p>On 8/8/13 at 5:00 p.m., the DNS reported she could not recall the incident and would start an investigation as soon as possible.</p> <p>Review of the facility's incident log and grievance log did not reveal the incident had been reported or investigated to rule out abuse/neglect. Further review of the record did not reveal the resident had been assessed to rule out psychological harm.</p> <p>Review of the facility's policy dated 2/9/09, for reporting alleged abuse documented, in part, the following:</p> <p>1) All alleged or suspected violations involving mistreatment, abuse, neglect, injuries of unknown origin (e.g., bruising and skin tears) will be promptly reported to the administrator and/or the director of nursing</p> <p>2) The abuse hotline is notified within 24 hours whenever there is an allegation of abuse.</p> <p>3) The administrator, director of nursing, or designated representative will complete an</p>	F 225			

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F 225	Continued From page 12 investigation of the incident including a written summary of the finding no later than five working days after the reported occurrence. 4) Following the report of suspected abuse and/or neglect, the administrator will designate a resident advocate (i.e., social services) to support the resident through his/her feelings about the incident and his/her reaction to their involvement in the investigation. On 8/9/13 at approximately 1:00 p.m., the executive director (ED) and the corporate vice president stated it is the expectation of the staff to report all allegations of suspected abuse and/or neglect to the facility's ED and/or the DNS, and the reported incident is immediately investigated.	F 225			
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure preferences were accommodated for 5 of 14 current sampled residents (#3, 38, 43, 75, & 102) reviewed for bathing choices. This failure placed residents at risk of not maintaining personal	F 246	F246 1. Resident #102 no longer resides at the facility. Resident # 3, 38, 43, and 75 were assessed with no negative outcome. 2. All residents were reviewed related to shower preferences and care plan updated as needed.		

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F 246	<p>Continued From page 13 cleanliness and diminished quality of life.</p> <p>Findings Include:</p> <p>The facility's Policy and Procedure from the Social Services Manual stated, "The Social Services Director ensures that facility systems are designed, implemented and monitored to provide residents information to make informed choices and decisions about their health, safety and life in the facility."</p> <p>1) Resident #3's Minimum Data Set (MDS), an assessment tool, dated 06/22/13, indicated a severe cognitive impairment and documented the need for physical assistance with bathing.</p> <p>Resident #3's shower record was reviewed. There was no documentation to support that the resident received a shower between 06/20/13 to 07/02/13 or from 07/18/13 to 08/07/13.</p> <p>On 08/08/13 at 2:13 p.m., NA D stated she was unable to give the resident a shower yesterday, on his scheduled day, because she was too busy.</p> <p>2) Resident #38's MDS, dated 07/12/13, documented diagnoses including [REDACTED] and [REDACTED] and the need for extensive assistance with most activities of daily living. According to the 07/12/13 MDS, bathing did not occur during the seven day assessment period. The resident's prior quarterly MDS assessments indicated extensive assistance was required for bathing.</p> <p>The shower record was reviewed for Resident #38 which showed showers were not provided from 06/04/13 to 07/08/13 and from 07/17/13 to</p>	F 246	<p>3. Staff educated to offer bed bath if resident declines shower.</p> <p>Showers are designated by room by day of the week and then by day/eve.</p> <p>4. Weekly shower audits will be completed x 4 weeks and then monthly. The results will be reviewed in monthly PI meeting.</p> <p>5. Date of correction 9.9.13.</p> <p>6. The Director of Nursing is responsible for ongoing compliance.</p>		

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F 246	<p>Continued From page 14 08/05/13.</p> <p>On 08/08/13 at 2:20 p.m., Resident #38's family member stated she usually gets one shower per week and stated, "That's not very much. Her hair gets greasy."</p> <p>3) Resident #43's MDS, dated 05/29/13, documented diagnoses including dementia and stroke, severe cognitive impairment and a need for physical assistance with bathing.</p> <p>The bathing record for Resident #43 indicated no showers or baths were provided to the resident between 07/25/13 to 08/07/13.</p> <p>On 08/08/13 at 2:13 p.m., NA D stated she was unable to give the resident a shower yesterday, on the resident's scheduled day, because she was too busy.</p> <p>4) Resident #75's MDS, dated 05/21/13 documented diagnoses including diabetes, stroke and hip fracture. The resident's MDS, indicated the resident required extensive assistance for bathing.</p> <p>On 08/08/13 at 1:40 p.m., Resident #75 stated, "They are really short staffed. I get a shower every two weeks. If I was home I would shower twice a week."</p> <p>The shower record was reviewed for Resident #75 which showed showers were not given to the resident from 06/15/13 to 06/26/13, 06/28/13 to 07/10/13 and 07/12/13 to 7/31/13.</p> <p>5) Resident #102 was admitted to the facility due to a fracture on 06/21/13. The resident stated she</p>	F 246		

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F 246	<p>Continued From page 15 showered daily at home.</p> <p>On 08/08/13 at 3:55 p.m., Resident #102 stated, "I was not asked how many showers I wanted but I have been offered one on Sundays. I try very hard to get a second one."</p> <p>On 08/07/13 at 2:25 p.m., The Executive Director stated, "We offer one shower per week. If a resident wants more they would need to request it."</p> <p>On 08/07/13 at 2:35 p.m., Nursing Assistant (NA) B stated he looks at a list to determine who gets a shower. He stated, "Today I have one bed bath."</p> <p>At 2:40 p.m., NAA stated, "I look at the list to see who needs a shower. I don't have anyone today."</p> <p>At 2:49 p.m., NA C stated, "Each aid usually gives one shower per shift. Today the room number on the schedule is an empty room so I don't have a shower to give."</p> <p>At 3:02 p.m., Occupational Therapy (OT) staff stated, "I give people showers on Saturdays. I have residents on the OT caseload approach me and ask, "Can you squeeze me in?"</p> <p>On 08/08/13 at 2:13 p.m., NA D stated she was unable to give two showers yesterday because she was busy. She stated, "I tried to do them today but couldn't squeeze them in."</p> <p>On 08/08/13 at 3:33 p.m., the Social Services Director stated residents are informed at care conferences that the facility's procedure is to offer one shower per week. She stated, "If they want more, they would need to ask for it."</p>	F 246		

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F 246	Continued From page 16	F 246		
F 325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(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</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to consistently obtain accurate weights for 1 of 3 current sampled residents (#51) reviewed for nutrition. This failure placed the resident at risk for unmet nutritional needs and weight loss.</p> <p>Findings include:</p> <p>Resident #51 admitted to the facility on [REDACTED] 3 with multiple diagnoses to include [REDACTED] and [REDACTED]. The 30 day minimum data set (MDS), an assessment tool, dated 5/11/13 identified the resident was independent with eating and required set up for meals. The resident no longer resided in the facility.</p> <p>The facility's weight monitoring policy dated 3/1/13 documented, in part, the following:</p>	F 325	<p>F 325</p> <ol style="list-style-type: none"> 1. Resident #51 no longer resides at the facility. 2. All residents were reviewed for weights. 3. Staff education completed on policies and procedures related to height/weight and nutrition. Restorative will complete 3 day admission weights, weekly weights, and monthly weights. A dedicated staff will enter weights into the computer system. 4. Ongoing weekly weight audits will be completed to ensure weights are obtained per policy. 	

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F 325	<p>Continued From page 17</p> <p>1) Weights and heights are obtained within 24 hours of admission/readmission and recorded in SoftCare2</p> <p>2) Weekly weights are obtained for new admissions weekly for 4 weeks</p> <p>3) Height and weight information is used to assess the resident's nutritional status, to formulate an appropriate nutritional care plan, to monitor appropriateness of interventions and for tracking prevalence of significant weight changes (gain or loss)</p> <p>Review of the facility's "nutritional data collection assessment," dated 4/13/13, revealed the Registered Dietician (RD) documented, in part, "weight is pending, however, hospital weight (129.1) used for needs above."</p> <p>The resident admitted to the facility on [REDACTED] 13, and facility staff did not obtain a weight within 24 hours, and did not weigh the resident weekly according to facility policy.</p> <p>On 04/13/13, the resident's nutritional needs were assessed by the previous RD based on the resident's hospital weight of 129 pounds. Review of the weight history revealed a documented weight of 129 pounds on 4/16/13.</p> <p>On 5/04/13, 18 days after the documented 4/16/13 weight, the resident weighed 122 pounds, a 5.4% weight loss.</p> <p>On 5/18/13, 14 days after the documented 5/04/13 weight, the resident weighed 118 pounds, an 8.5% significant weight loss. There were no other documented weights.</p>	F 325	<p>5. Director of Nursing will ensure ongoing compliance</p> <p>6. Date of correction 9.9.13</p>	
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F 325	Continued From page 18 According to the documentation, the previous RD reviewed the residents weight loss on 5/30/13 and made dietary recommendations 26 days after the initial weight loss noted on 5/04/13. On 8/08/13 at approximately 12:30 p.m., the current RD reported she would use the hospital weight to do an initial assessment if a facility weight was not available. The RD stated she would ask staff to obtain a facility weight for an accurate determination of estimated nutritional needs. When asked why a facility weight is preferred, the RD stated a facility weight is preferred due to scale differences, and possible differences in subsequent weights that could be related to certain medical conditions or edema. On 8/08/13 at 1:06 p.m., Licensed Nurse (LN) Y stated the resident would refuse care which may be the reason why weights were not obtained, and was unable to provide documented evidence that the resident refused to be weighed. LN Y stated weights should have been obtained on admit and weekly thereafter for 4 weeks. LN Y confirmed the resident had not been weighed according to the facility's policy. Although a physician's order dated 6/12/13 documented expected weight loss due to resident's recent decline and chronic condition. The facility failed to consistently obtain accurate weights before the resident's change in condition. This failure placed the resident at risk for unmet nutritional needs, and further unplanned weight loss.	F 325		
F 465	483.70(h)	F 465		

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F 465 SS=D	<p>Continued From page 19</p> <p>SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain 1 of 2 resident snack refrigerators/freezers in a sanitary manner. This failure placed residents at risk to receive snacks exposed to unsanitary conditions.</p> <p>Findings include:</p> <p>On 8/7/13 at 11:46 a.m., the resident snack refrigerator in the nurse's station on C wing was observed with items frozen and stuck into the upper freezer section. The refrigerator had a red sticky substance and crumbs on the lower refrigerator level. The refrigerator also contained unlabeled items such as condiments, yogurt and soda.</p> <p>On 8/8/13 at 9:44 a.m., the C wing snack fridge was observed filled with the same food items frozen solid into the upper freezer section. A sticky red substance and crumbs were visible on the lower level. Unlabeled items are still in resident snack fridge.</p> <p>At 1:36 p.m. Housekeeper (HK) A, stated, "I'm not really sure what the cleaning schedule is for the nurse's station fridge, but I could check in to it."</p>	F 465	<p>F465</p> <ol style="list-style-type: none"> 1. Resident refrigerator on C-Wing was cleaned and is in a sanitary manner. 2. All other refrigerators in use were reviewed for sanitary conditions. 3. Facility established a cleaning schedule. 4. Daily rounds are ongoing and staff assigned to resident care areas and will check resident refrigerators to ensure sanitary conditions. 5. The Executive Director will ensure ongoing compliance. 6. Date of correction 9.9.13.

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F 465	Continued From page 20 At 12:43 p.m., the Environmental Services Director (ESD) stated the refrigerator in the C wing nurse's station is scheduled for cleaning two times a week. They check dates, wipe up spills, and check temperature. The freezer was scheduled to defrost once a month. ESD confirms the refrigerator needs to be cleaned and defrosted, "It is overdue and we will be doing that today. I won't lie to you, it is overdue."	F 465			