

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

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FORM APPROVED
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1216

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/30/2013
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NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE	STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Martha and Mary Health Services on 05/20/13, 05/21/13, 05/22/13, 05/23/13, 05/24/13, 05/28/13, 05/29/13 and 05/30/13. A sample of 45 residents was selected from a census of 161. The sample included 33 current residents and the records of 12 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>██████████ RN, BSN ██████████ RN, BSN, MSN ██████████ RN, BSN, MBA ██████████ RN, BSN, MN</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, Unit A 1949 South State Street, MS: N27-24 Tacoma, Washington, 98405-2850</p> <p>Telephone: (253) 983-3800 Fax: (253) 589-7240</p> <p><i>[Signature]</i> Signature</p> <p>6/12/13 Date</p>	F 000	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 26 Jun 2013
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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 154 SS=D	<p>483.10(b)(3), 483.10(d)(2) NOTICE OF RIGHTS AND SERVICES</p> <p>The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.</p> <p>The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being.</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 fully inform the surrogate decision maker of risks/benefits associated with use of a tilt in space wheelchair for 1 of 3 Sampled Residents (#164) reviewed for accidents of the 45 residents who were included in the Stage 2 review. This prevented the decision maker from making an informed decision regarding use of an assistive device.</p> <p>Findings include:</p> <p>Resident #164 admitted to the facility on [REDACTED] 13. Diagnoses listed included care for [REDACTED] of a [REDACTED] and [REDACTED]</p> <p>A Care Area Assessment Summary dated 4/2/13 documented, prior to admission, the resident fell</p>	F 154	<p>F154: Facility informed the surrogate decision maker for Resident #164 of risks/benefits regarding use of tilt-in-space wheelchair and obtained written consent for continued use of the tilt-in-space wheelchair on 30 May 13.</p> <p>Facility will reassess residents and inform residents' surrogate decision makers of risks/benefits regarding use of tilt-in-space wheelchairs as well as other reclining wheelchairs and obtain written consent for continued use.</p> <p>Facility will update Policy & Procedure regarding use of reclining wheelchairs to include requirement to inform residents and/or their surrogate decision makers of risks/benefits of reclining wheelchairs as well as obtain consent for their use. Facility will in-service Interdisciplinary Team (IDT) on revised Policy & Procedure.</p> <p>Facility will audit residents' records quarterly to ensure risks/benefits have been provided and consents for reclining wheelchairs have been received. Discrepancies will be immediately corrected. QA&A Committee will monitor for compliance and follow-up as needed.</p> <p>Continued on Page 3 of 55</p>		

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F 154	<p>Continued From page 2</p> <p>after attempting to get up out of a chair and [REDACTED]. The assessment identified the resident had cognitive impairment and the family reported the resident susceptible to recurrent [REDACTED] and tended to become lethargic or overly hyper/restless from the infection.</p> <p>On 5/21/13 at 11:18 a.m. Resident #164 sat unsupervised in his/her room in a wheelchair reclined 25 degrees from an upright position (tilt in space wheelchair). The resident appeared comfortable and did not respond and engage in conversation when spoken to.</p> <p>On 5/28/13 at 11:14 a.m. the resident sat unsupervised in his/her room in a tilt wheelchair reclined at 20 degrees and did not respond verbally.</p> <p>Therapy treatment records dated 3/29/13 identified resident and family goals for Resident #164 were for the resident to be safe.</p> <p>Therapy notes documented on 4/2/13 therapy staff implemented a trial of a reclining wheelchair.</p> <p>A faxed note to Resident #164's physician dated 5/15/13 stated "Resident continually sliding out of wheelchair and feet falling through leg rest." Staff requested an order for therapy to reevaluate for a new wheelchair.</p> <p>On 5/17/13 therapy notes identified therapy made wheelchair modifications to address the positioning problem. On 5/21/13 therapy documented they updated Resident #164's plan of care to recline the wheelchair at least 15</p>	F 154	<p>Continued from Page 2 of 55</p> <p>Corrective action will be completed by 14 Jul 13.</p> <p>Director of Nursing and Administrator will ensure on-going compliance.</p>	

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F 154	<p>Continued From page 3</p> <p>degrees when unsupervised to prevent the resident from leaning forward and for improved comfort and positioning.</p> <p>On 5/21/13 at 1:31 p.m. Staff S reported Resident #164 had been non-weight bearing and just recently had therapy and could now stand during transfers.</p> <p>Resident #164's medical record did not contain evidence staff fully informed the resident's decision maker regarding potential risks and benefits of the tilt wheelchair, such as, injury if the resident's activity increased during a [REDACTED] or the resident attempted to get out of the wheelchair.</p> <p>On 5/29/13 at 7:07 a.m. Staff B reported the facility did not obtain risk/benefit consents for tilt in space wheelchairs. Staff B reported risks associated with tilt in space wheelchair use included problems if tilting the wheelchair during eating.</p> <p>The facility implemented use of an assistive device as part of the treatment plan for Resident #164 prior to informing the decision maker of all risks and benefits associated with its use. This prevented the decision maker from having the opportunity to accept or decline use of the device.</p>	F 154	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</p>		
F 157 SS=D	<p>483.10(b)(11) NOTIFICATION OF CHANGES</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an</p>	F 157	<p>F157: Facility provided Resident #171's physician a detailed description/update of Resident #171's wound via fax on 29 May 13.</p> <p>Continued on Page 5 of 55</p>		

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F 157	<p>Continued From page 4</p> <p>accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to timely inform the physician of the condition and change in condition of a sacral pressure ulcer for 1 of 5 Sampled Residents (#171) reviewed for pressure ulcers of the 45 residents included in the Stage 2 review. This prevented the physician from having an opportunity to change the plan of treatment for</p>	F 157	<p>Continued from Page 4 of 55</p> <p>Facility will review residents with pressure ulcers to ensure physician notifications have been made to include description of current condition and physicians have opportunity to modify plan of care/treatment as appropriate.</p> <p>Facility will in-service licensed nurses on requirement to inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative when there is a significant change in the resident's physical, mental or psychological status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility.</p> <p>Facility will conduct weekly wound rounds and report changes of wound conditions to physicians as appropriate for further investigation. Unit/Case Managers will monitor physician notification. QA&A Committee will monitor compliance and follow-up accordingly.</p> <p>Corrective action will be completed by 14 Jul 13.</p> <p>Director of Nursing and Administrator will ensure on-going compliance.</p>		

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F 157	<p>Continued From page 5 this resident.</p> <p>Findings include:</p> <p>Resident #171 admitted to the facility on [REDACTED]/13. The resident went to the hospital twice following admission due to [REDACTED] and readmitted on [REDACTED]/13 and [REDACTED]/13.</p> <p>During the first and second admissions the resident developed a [REDACTED]</p> <p>During the first admission, on 3/7/13, a "Skin Impairment" form identified the resident had a [REDACTED] (opened skin surface) that measured 1.5 cm by 1.5 cm. The following week the ulcer increased in size to 2.5 cm by 1.5 cm. The record did not contain evidence staff provided a description of the wound to the physician when they requested to use house wound protocols to treat the [REDACTED].</p> <p>During the second admission staff sent a fax to the physician on 4/28/13 when Resident #171 developed a skin concern. The statement on the fax stated "[REDACTED] 5.0 cm x 5.0 cm black bruise with 2.0 cm x 2.0 cm yellow slough area alongside. No drainage from pressure sore. No odor." Slough is tissue that is separating from the wound bed. Staff requested to follow the house wound protocol to treat and the physician agreed on 4/29/13.</p> <p>On 5/5/13 a "Skin Impairment" form described the same ulcer had a 3.0 cm x 1.0 cm area of eschar (necrotic tissue) and described the wound as unstageable (unable to determine depth and severity of the wound).</p>	F 157	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.		

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F 157	<p>Continued From page 6</p> <p>The record did not contain evidence staff informed the physician of the change in the condition of the wound.</p> <p>Resident #171 re-admitted to the facility on [REDACTED] 13 with the same previous [REDACTED]. Staff documented on skin forms the ulcer measured 4.5 cm by 2.5 cm. The next day, on 5/18/13, staff described on a skin form the ulcer had a ring of blanchable redness and contained an area of eschar surrounded by slough.</p> <p>Staff obtained an order from the physician to treat the [REDACTED] according to house protocol. No evidence was found in the record staff provided the physician with a description of the [REDACTED] with eschar prior to obtaining the order.</p> <p>Physician notes did not identify the physician observed the condition of the [REDACTED].</p> <p>On 5/29/13 at 8:13 a.m., when asked if nursing contacted the physician regarding the description of Resident #171's [REDACTED], Staff G reported Staff H "is good about calling" physicians.</p> <p>On 5/29/13 at 9:21 a.m. Staff H reported he/she left a voice mail to the physician on 5/23/13 regarding the [REDACTED]. When asked what information was provided regarding the wound on the voicemail, Staff H reported he/she read the fax that was sent to the physician that day. The fax documented for the physician the resident had recent weight loss of 11 pounds and had a "sacral wound." The fax did not contain further information describing the condition of the wound/[REDACTED].</p>	F 157	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</p>	
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F 157	Continued From page 7 The facility did not provide evidence they fully informed the physician regarding the condition of the [REDACTED] at the time of admission and readmission or when the wound declined in condition. This prevented the physician from having an opportunity to determine if alternative treatment/s other than the house wound protocol should be implemented. Following surveyor inquiry regarding physician notification, the facility provided a copy of a fax sent to the physician on 5/29/13 at 3:31 p.m. which contained a detailed description of the condition of the wound.	F 157			
F 242 SS=D	483.15(b) SELF-DETERMINATION AND PARTICIPATION The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to consistently honor or follow their policy to assess resident preferences for frequency of showering and/or bathing for 2 of 3 Sampled Residents (#s 6 & 24) reviewed for choices of the 45 residents who were included in the Stage 2 review. This failure prevented residents from exercising their right to make choices regarding their care and	F 242	F242: Facility provided survey team on 30 May 13 an IDT Note indicating a care conference was completed for Resident #24 on 6 Dec 12. Resident #24 was interviewed by Unit MDS Nurse regarding his stated preference, at the time of survey, for showers two times weekly. At that time, Resident #24 declined two showers weekly stating, "...Just Fridays is plenty here." Resident #24 and surrogate decision maker were invited to a care conference on 7 Jun 13 for further follow-up. Neither attended and no additional concerns were shared/noted regarding Resident #24's preference for two weekly showers. Unit IDT will continue to assess and monitor Resident #24 for his preferences related to showers and update his care plan as appropriate. Facility will conduct a care conference with Resident #6 to confirm Resident #6's preference for frequency of showers and will establish a plan to reschedule or provide alternative care if showers are missed according to Resident #6's care plan. Continued on Page 9 of 55		

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F 242	<p>Continued From page 8</p> <p>had the potential to decrease their quality of life.</p> <p>Findings include:</p> <p>RESIDENT #24 Resident #24 was admitted to the facility on [REDACTED] 12 from an [REDACTED] with diagnoses to include a [REDACTED] with [REDACTED]</p> <p>The Minimum Data Set (MDS), an assessment tool, dated 3/7/13, indicated Resident #24 was non-ambulatory and completely dependent on facility staff for most activities of daily living (ADLs), including bathing, dressing and locomotion on the unit with use of a wheelchair. Resident #24's Brief Interview for Mental Status (BIMS) score was 13, indicating he was cognitively intact.</p> <p>On 5/21/13 at 10:14 a.m., during an interview, Resident #24 stated he/she received a shower twice weekly at the assisted living facility. Resident #24 reported a strong preference for two baths or showers per week but stated the facility only offered one per week. Resident #24 stated no staff member asked about preferences for frequency of bathing.</p> <p>Resident #24's Care Plan for ADLs, dated 12/12/12, indicated the resident would be bathed once weekly with two-person assistance. Resident #24's ADL logs for February through May 2013 reflected he/she was bathed once weekly on Fridays.</p> <p>On 5/24/13 at 9:53 a.m., during an interview, the unit manager, Staff T, stated that facility policy</p>	F 242	<p>Continued from Page 8 of 55</p> <p>Facility will assess and review residents' preferences for frequency of showering and/or bathing and update care plans as appropriate.</p> <p>Facility will update Policy & Procedure regarding assessing and providing residents' showers and/or baths including requirement to reschedule or provide alternative care if showers and/or baths are missed according to resident care plans. Facility will in-service nursing staff on revised Policy & Procedure.</p> <p>Facility will conduct monthly audits to ensure residents are receiving showers and/or baths according to preferences/care plan. Discrepancies will be immediately corrected. QA&A will monitor compliance and follow-up as needed.</p> <p>Corrective action will be completed by 14 Jul 13.</p> <p>Director of Nursing and Administrator will ensure on-going compliance.</p>		

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F 242	<p>Continued From page 9</p> <p>was to assess resident preferences for issues such as frequency of bathing within 48 to 72 hours after admission. Staff T further stated that residents were bathed once per week unless the resident requested a different schedule; residents may request more than one bath or shower per week but additional baths/showers were provided only after all other residents had received at least one bath/shower that week.</p> <p>Staff T stated that frequency of bathing was among the issues addressed during a care conference with the resident or the resident's representative and an interdisciplinary team of staff members. Staff T reviewed Resident #24's chart and reported there was no documentation to verify a care conference was done for Resident #24 or that staff had addressed the issue of bathing frequency with Resident #24 to ascertain his/her preference.</p> <p>On 5/29/13 at 10:02 a.m., during an interview, the MDS nurse, Staff U, reviewed Resident #24's chart and stated there was no documentation to verify a care conference was done with Resident #24.</p> <p>RESIDENT #6 On 5/21/13 at 2:12 p.m. Resident #6 reported he/she was scheduled for showers twice a week but usually received only one.</p> <p>On 5/23/13 at 2:00 p.m. the resident appeared dressed and well groomed while seated in a wheelchair.</p> <p>On 5/23/13 sat 2:33 p.m. Staff Q showed the</p>	F 242	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.		

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F 242	<p>Continued From page 10</p> <p>surveyor a shower schedule and reported Resident #6's shower days were Monday and Thursday each week. Staff Q confirmed the resident was scheduled to receive showers twice a week.</p> <p>On 5/23/13 at 2:37 p.m. Staff N reported Resident #6 made his/her own decisions, did not refuse showers and sometimes wanted showers changed to a different time or day.</p> <p>On 5/24/13 at 9:41 a.m. the resident reported he/she wanted to shower both days and especially wanted to shower on Thursday to feel clean before an outside weekend activity attended regularly. Resident #6 reported Staff N informed him/her shower aides sometimes could not provide showers twice a week.</p> <p>Shower records documented Resident #6 received only 3 out of 8 showers scheduled during February 2013; 7 out of 8 showers scheduled during March 2013 and 3 out of 10 showers scheduled during April 2013. The May 2013 shower schedule documented the resident did not receive a shower on Thursday 5/2/13; Monday 5/13/13 or Thursday 5/16/13 as scheduled.</p> <p>On 2/12/13, shower staff circled their initials and wrote a note on the back of the shower schedule they were unable to shower the resident due to staffing issues and notified the nurse. Staff circled their initials on other missed shower days but did not provide an explanation on the back of the record describing the reason the resident did not receive a shower. No evidence was found in the record staff offered to reschedule the Resident</p>	F 242	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.		

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F 242	Continued From page 11 #6's showers when they were missed. On 5/24/13 at 9:07 a.m. Staff Q reported when initials were circled on the shower record it indicated shower aides were pulled to the floor and they did not have an opportunity to shower the resident. Staff Q reported shower aides report missed showers to nursing but did not reschedule them and again confirmed Resident #6 did not refuse showers. Resident #6 voiced preference for two showers a week and the facility failed to provide them according to their pre-determined schedule or reschedule the shower when the resident did not receive one according to schedule.	F 242			
F 280 SS=E	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	F280: Resident #24 was interviewed by Unit MDS Nurse regarding his stated preference, at the time of survey, for showers two times weekly. At that time, Resident #24 declined two showers weekly stating, "...Just Fridays is plenty here." Resident #24 and surrogate decision maker were invited to a care conference on 7 Jun 13 for further follow-up. Neither attended and no additional concerns were shared/noted regarding Resident #24's preference for two weekly showers. Unit IDT will continue to assess and monitor Resident #24 for his preferences related to showers and update his care plan as appropriate. Resident #86's nutritional care plan has been reviewed and updated. Resident #158 expired on 12 May 13. Resident #171's care plan has been reviewed and updated to reflect interventions to prevent and/or promote pressure ulcer healing. Resident #274 discharged on 31 May 13. Facility will continue to review and update resident care plans as necessary to ensure individual care needs are being met. Continued on Page 13 of 55		

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F 280	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to either review and revise nutrition, pressure ulcer, bathing and/or dehydration care plans, or afford an opportunity to participate in care planning for 5 of 44 Sampled Residents (# 24, 86, 158, 171 & 274) of the 45 residents who were included in the Stage 2 review. These failures placed residents at risk for not having their individual care needs met. Findings include: RESIDENT #171 PRESSURE ULCER PLAN OF CARE Refer to F 314 and F 325 for additional medical history, observations and information regarding weight loss and a [REDACTED] for Resident #171. Resident #171 was admitted to the facility on [REDACTED]/13 with a red and [REDACTED] area on the [REDACTED]s. The facility assessed the resident for risks for developing a [REDACTED] and developed a plan of care titled "Skin at Risk" related to [REDACTED] and decreased mobility. The initial plan of care contained three approaches with start dates of 3/7/13: -report all skin issues to nurse -treatment per order -risk scale on admit, quarterly and as needed for changes in condition	F 280	Continued from Page 12 of 55 Facility will update <i>Care Plan Policy & Procedure</i> and in-service IDT. Facility will audit resident care plans quarterly to ensure individual care needs are addressed. Discrepancies will be corrected immediately. QA&A Committee will monitor compliance and follow-up as needed. Corrective action will be completed by 14 Jul 13. Director of Nursing and Administrator will ensure on-going compliance.		

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F 280	<p>Continued From page 13</p> <p>The initial skin at risk plan of care did not contain comprehensive approaches staff should consistently implement to attempt to prevent development of a pressure ulcer, such as, turning and repositioning schedule, positioning needs in bed and in the wheelchair, maximum length of time for sitting when in a wheelchair and the type of wheelchair cushion needed for a resident who could not independently offload.</p> <p>On 3/7/13 staff identified Resident #171 developed a [REDACTED] (compromise to the surface of the skin).</p> <p>The record did not contain evidence the facility updated the resident's plan of care to incorporate additional interventions required to promote healing. The care plan did not identify dates and specific interventions the facility reported they had implemented such as an air mattress and specialty wheelchair cushion.</p> <p>When Resident #171 was readmitted to the facility on [REDACTED]/13, the same previous skin at risk care plan with the same three approaches were used. Staff changed the start dates from 3/7/13 to 5/8/13.</p> <p>On 4/28/13 staff identified the resident had an unstagable ulcer. The record did not contain evidence staff updated the plan of care to develop additional comprehensive approaches needed to promote wound healing.</p> <p>When Resident #171 was re-admitted to the facility on [REDACTED] 13 with an [REDACTED]e [REDACTED], the facility did not update the plan of care to reflect all interventions to promote healing.</p>	F 280	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.		

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F 280	<p>Continued From page 14</p> <p>On 5/23/13 at 9:31 a.m. Staff E reported all of Resident #171's risk factors for skin breakdown should be addressed on the care plan.</p> <p>NUTRITION PLAN OF CARE Following all admissions on 2/19/13, 4/20/13 and 5/16/13 Resident #171's record contained a plan of care titled "Alteration Nutrition Status" related to hip surgery. Approaches included:</p> <ul style="list-style-type: none"> -diet as ordered -weekly weights -assess likes and dislikes. <p>The resident lost weight and developed a [REDACTED]. Dietary staff made recommendations on 4/8/13 and 5/2/13 to stabilize weight and promote healing. The care plan did not reflect any updated nutritional approaches or interventions all nursing and dietary staff needed to implement to address nutritional concerns for Resident #171.</p> <p>Following surveyor inquiry, on 5/29/13, Staff J provided the surveyor with an updated nutrition plan of care to reflect additional interventions provided to the resident.</p> <p>RESIDENT #158 DEHYDRATION Refer to F 327 for medical history and additional information related to failure to monitor hydration status for Resident #158.</p> <p>The facility sent Resident #158 to the emergency room (ER) on 4/22/13 for treatment of dehydration. The physician ordered additional IV</p>	F 280	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</p>		

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F 280	<p>Continued From page 15 fluids in the facility beginning [REDACTED]/13 and [REDACTED]13.</p> <p>A care plan for dehydration due to diuretic use initiated 4/17/13 identified to assess for dehydration and report changes to the physician.</p> <p>Following return from the ER on 4/22/13 with a diagnosis of dehydration, staff did not update the plan of care to identify specific interventions they needed to implement to conduct dehydration assessment and monitoring, such as, Resident #158's daily minimum fluid intake requirement, monitoring of intake and output, frequency of monitoring for specific signs and symptoms such as dry oral mucosa, decreased skin turgor and change of mental status.</p> <p>The facility Policy & Procedure for Hydration Management directs staff to monitor intake and output for residents who have a diagnosis of dehydration. Staff did not implement intake and output monitoring for Resident #158. The resident's record did not contain evidence staff comprehensively assessed hydration status following a diagnosis of dehydration.</p> <p>On 5/8/13 at 9:54 a.m. Staff D reported a change of condition care plan should have been completed for Resident #158. Staff D also reported the nurse on the floor who admitted the resident was responsible to implement new care plan issues.</p> <p>RESIDENT #86 NUTRITION On 5/23/13 at 11:15 a.m. Resident #86 stated: "I did not make it to breakfast today, I slept in." "I am not a very big breakfast eater anyway." The</p>	F 280	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.		

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F 280	<p>Continued From page 16</p> <p>resident reported she prefers dinner over other meals.</p> <p>On 5/23/13 at 12:29 p.m. Resident #86 ate all of his/her lunch. The resident's tray card indicated the resident was receiving an Every Bite Counts (EBC) diet with medium portions.</p> <p>On 5/23/13 at 12:35 p.m. Staff K reported there was no monitoring of Resident #86's EBC diet.</p> <p>On 5/23/13 at approximately 12:30 p.m. during the lunch meal, Staff L reported Resident #86 meal intake was not required to be monitored.</p> <p>Resident #86 was admitted on [REDACTED] 13 with an admit weight of 102.1 pounds.</p> <p>An initial registered dietician (RD) evaluation dated 2/9/13 recommended to encourage by mouth intake, assist with meals as needed and weekly weights with a goal to meet nutritional needs with current intake and stabilize weights.</p> <p>The next weight taken on Resident #86's after admission (2/9/13) was on 2/25/13 and recorded on the resident's "Weight Record" as 96.5 pounds. The word "standing" was hand written next to this weight entry. There was no assessments to determine why the resident's weight had dropped from 102.1 pounds on 2/9/13 to 96.5 pounds on 2/25/13. The resident was not re-weighed on 2/25/13 to determine if the weight taken was accurate. The resident's weight was not taken again until 3/27/13 where it was documented the resident weighed 103 pounds.</p> <p>On 5/23/13 at 11:55 a.m. Staff M reviewed</p>	F 280	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.		

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F 280	<p>Continued From page 17</p> <p>Resident #86's admit weight on 1/13 of 102 pounds and the resident's next weight on 2/25/13 of 96 pounds. Staff M reported the the resident's weight should have been re-weighed on 2/25/13 when it was 96 pounds to determine if the weight was accurate.</p> <p>On 5/24/13 at 9:00 a.m. Staff N reported it is not the policy that EBC diets are recorded as to how much is eaten by the resident. Staff N reported when a resident has a weight change they are re-weighed. If the weight stays low, the physician will be called for orders, the RD will be notified.</p> <p>A RD saw Resident #86 on 3/18/13 for a weight referral and documented the resident's weight taken on 2/25/13 96.5 was down from 2/9/13 of 102. Meal intake varies and some meals resident eats greater than 75%. RD recommended adding EBC protocol to diet. RD documented resident weight is down despite good intake and suspect resident burns high kilocalorie (KCAL) secondary to being quite busy during day.</p> <p>Record review noted on 3/18/13 staff notified the resident's physician of the resident's weight loss to 96.5 pounds on 2/25/13 requesting an EBC protocol be added to diet to increase KCAL.</p> <p>Review of Procedure, provided by the facility for "Weights" section VI reads:</p> <p>A. Report fluctuations promptly to charge nurse B. Charge nurses are to notify the physician of weight losses or gains of plus or minus 5 pounds or 5%. C. The dietician is to evaluate all weight losses or gains of plus or minus 5 pounds or 5%.</p>	F 280	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.		

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F 280	<p>Continued From page 18</p> <p>D. all resident will be weighed at least monthly and upon admission.</p> <p>On 5/24/13 at 1:30 p.m. Staff E was briefed on Resident #86 weights on 2/9/13 (102) and on 2/25/13 (96.5). Staff E reported she/he would review the weights for Resident #86.</p> <p>On 5/28/13 at 12:46 p.m. Staff E reported Resident #86 should have been re-weighed on 2/25/13 when his/her weight was 96.5 pounds to determine if the weight was correct.</p> <p>On 5/29/13 at 1:10 p.m. Staff A, Staff B and Staff E were briefed on Resident #86's weight fluctuation on 2/9/13 of 102 pounds and on 2/25/13 of 96.5 pounds.</p> <p>On 5/30/12 at approximately 2:00 p.m. Staff A, Staff B and Staff E did not provide further evidence of assessment of Resident #86's weight fluctuation between 2/9/13 and 2/25/13.</p> <p>The facility failed to re-weigh Resident #86 on 2/25/13 when the resident's weight was 96.5 a difference of 5.5 pounds from the resident's admit weight on 2/9/13 of 102 pounds to determine if the weight taken on 2/25/13 was correct and to determine if the resident's nutritional plan of care should be revised. The facility did not notify the physician of the resident weight fluctuation and revise the resident plan of care until 3/18/13. These failures placed the resident at potential risk for not having his/her nutritional needs met.</p> <p>Refer to F281 Resident #86 for failure to follow professional standards of practice and revise the resident nutritional care plan after a weight</p>	F 280	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.		

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F 280	<p>Continued From page 19 fluctuation.</p> <p>RESIDENT #24 Resident #24 was admitted to the facility on [REDACTED]/12 from an assisted living facility with diagnoses to include a history of [REDACTED] with left [REDACTED].</p> <p>The Minimum Data Set (MDS), an assessment tool, dated 3/7/13, indicated Resident #24 was non-ambulatory and completely dependent on facility staff for most activities of daily living (ADLs), including bathing, dressing and locomotion on the unit with use of a wheelchair. Resident #24's Brief Interview for Mental Status (BIMS) score was 13, indicating he was cognitively intact.</p> <p>On 5/21/13 at 10:14 a.m., during an interview, Resident #24 stated he/she received a shower twice weekly at the assisted living facility. Resident #24 reported a strong preference for two baths or showers per week but stated the facility only offered one per week. Resident #24 stated no staff member asked about preferences for frequency of bathing.</p> <p>Resident #24's Care Plan for ADLs, dated 12/12/12, indicated the resident would be bathed once weekly with two-person assistance. Resident #24's ADL logs for February through May 2013 reflected he/she was bathed once weekly on Fridays.</p> <p>On 5/24/13 at 9:53 a.m., during an interview, the unit manager, Staff T, stated that facility policy was to assess resident preferences for issues such as frequency of bathing within 48 to 72</p>	F 280	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.	

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F 280	<p>Continued From page 20</p> <p>hours after admission. Staff T further stated that residents were bathed once per week unless the resident requested a different schedule; residents may request more than one bath or shower per week but additional baths/showers were provided only after all other residents had received at least one bath/shower that week.</p> <p>Staff T stated that frequency of bathing was among the issues addressed during a care conference with the resident or the resident's representative and an interdisciplinary team of staff members. Staff T reviewed Resident #24's chart and reported there was no documentation to verify a care conference was done for Resident #24 or that staff had addressed the issue of bathing frequency with Resident #24 to ascertain his/her preference.</p> <p>On 5/29/13 at 10:02 a.m., during an interview, the MDS nurse, Staff U, reviewed Resident #24's chart and stated there was no documentation to verify a care conference was done with Resident #24.</p> <p>RESIDENT #274 NUTRITION CARE PLAN 05/24/13 at 7:54 a.m. Resident #274 independently ate breakfast and consumed most of food including eggs, sausage and a huckleberry coffee cake.</p> <p>A registered dietitian (RD) nutritional assessment dated 05/15/13 identified Resident #274 was admitted on [REDACTED] 13 with a weight of 122.9 pounds and a Body Mass Index (BMI) of 20.5 kilograms/m². The RD recommended</p>	F 280	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.	

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F 280	Continued From page 21 monitoring the resident's weights, labs and start multivitamins (MVI) with minerals to be added to the resident 's plan of care. Review of Resident #274's medication administration record for May 2013 noted no orders for multivitamins as recommended by the RD on 5/15/13. On 5/23/13 at 11:15 a.m. and 12:57 p.m. Staff J reported his/her dietary recommendations are placed into binders for individually identified physicians. When these physician's visit the resident, they look at the binder and make a decision on whether or not to follow up on Staff J's recommendations. Staff J was not aware his/her recommendation for Multivitamins had not been reviewed by the resident's physician for approval and implementation into the resident's plan of care. Further record review noted a physician telephone order dated 5/26/13 directing staff to start multivitamin with minerals one by mouth daily to be added to the resident's plan of care. The facility failed to have a system to ensure recommendations made by registered dietician would receive a timely review to determine if his/her recommendations needed to be added to the resident's plan of care. Refer to F281 Resident #274 for failure to follow professional standards of practice to ensure timely implementation of RD recommendation.	F 280			
F 281 SS=E	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility	F 281	F281: Facility reviewed and confirmed Resident #86's weight has remained stable despite the weight discrepancy recorded on 25 Feb 13. Facility reviewed Resident #171's nutritional status and recommendations to ensure interventions were implemented. Resident #249 expired on 13 May 13. Resident #274 discharged on 31 May 13. Continued on Page 23 of 55		

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F 281	<p>Continued From page 22 must meet professional standards of quality.</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 follow professional standards of practice for 4 of 6 Sampled Residents (#s 86, 171, 249 & 274) reviewed for either nutrition and/or skin conditions of the 45 residents who were included in the Stage 2 review. These failures placed residents at potential risk for not having their individual needs met.</p> <p>Findings include:</p> <p>Washington State Nursing Practice Act, WAC 246-840, states that nurses are responsible to perform care according to accepted standards of practice that include but are not limited to: ongoing client assessment and evaluation of responses to interventions; timely communicate significant changes in the client's status to appropriate members of the healthcare team; and document, on essential client records, the nursing care given and response to that care.</p> <p>According to Lippincott, Williams & Wilkins, Fundamentals of Nursing, 7th Edition, 2011, page 125, "Nurses are legally responsible for carrying out the orders of the physician in charge of a patient"</p> <p>According to Lippincott, page 937, assessment</p>	F 281	<p>Continued from Page 22 of 55</p> <p>Facility will assess residents to ensure professional standards of practice are being followed for care areas including but not limited to nutrition and/or skin conditions.</p> <p>Facility will in-service licensed nurses on professional standards of practice including on-going resident assessment and evaluation of responses to interventions, timely communication of significant changes; and documentation of nursing care given and resident responses/outcomes. Specifically, Facility will in-service licensed nurses on standards of practice related to pressure ulcers and nutritional assessments.</p> <p>Facility will conduct resident chart and care plan reviews quarterly for compliance. Discrepancies will be immediately corrected. QA&A Committee will monitor compliance and follow-up as needed.</p> <p>Corrective action will be completed by 14 Jul 13.</p> <p>Director of Nursing and Administrator will ensure on-going compliance.</p>	
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F 281	<p>Continued From page 23</p> <p>and evaluation of existing pressure ulcers " involves inspection (sight and smell) and palpation for appearance, drainage, odor and pain.provides essential baseline data and information to judge the effectiveness of treatment and wound healing progression. Skin integrity and wound assessment are performed at regular intervals, based on the nature of the wound and facility policy. "</p> <p>According to Lippincott, pages 1178-1179, weight loss is a sign of potential "poor nutritional status.As soon as problems are identified, [they should be referred] to appropriate services, including a dietician."</p> <p>RESIDENT #249 Former Resident #249 was admitted to the facility on [REDACTED]/13 and [REDACTED] on [REDACTED]/13.</p> <p>On 5/24/13 at 11:06 a.m. Staff C, who completed the Resident #249's Admission MDS dated 2/28/13, reported the resident's [REDACTED] [REDACTED] was developed after admission to the facility on [REDACTED]/13.</p> <p>Review of Resident #249's record noted the resident was first assessed to have a Stage 2 [REDACTED] pressure ulcer on 2/26/13. The next assessment of the resident's pressure ulcer was on 3/29/13 which indicated the resident's wound was "Discontinued-Resolved." .</p> <p>A physician's order dated 2/26/13, the same day the resident's pressure ulcer was first identified, directed staff to start [REDACTED] a prescribed treatment, to the resident's [REDACTED] QOD (every</p>	F 281	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.		

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F 281	<p>Continued From page 24 other day) and as needed (prn).</p> <p>Review of the treatment record for March 2013 showed the prescribed treatment [REDACTED] was not consistently changed QOD as ordered by the physician during the month of March 2013.</p> <p>The facility failed to follow professional standards of practice by failing to conduct ongoing assessments of Resident #249's Stage 2 [REDACTED] pressure ulcer and ongoing assessments of the effectiveness of prescribed pressure ulcer treatment ([REDACTED]). In addition, the facility failed to follow professional standards of practice by failing to consistently apply a prescribed [REDACTED] treatment QOD and prn as ordered by the resident's physician during the month of March 2013.</p> <p>Refer to F 314 Resident #249 for failure to provide pressure ulcer care and services.</p> <p>RESIDENT #86 On 5/23/13 at 11:15 a.m. Resident #86 stated: "I did not make it to breakfast today, I slept in." "I am not a very big breakfast eater anyway." The resident reported she prefers dinner over other meals.</p> <p>On 5/23/13 at 12:29 p.m. Resident #86 ate all of his/her lunch. The resident's tray card indicated the resident was receiving an Every Bite Counts (EBC) diet with medium portions.</p> <p>An initial registered dietician (RD) evaluation dated 2/9/13 recommended to encourage by mouth intake, assist with meals as needed and weekly weights with a goal to meet nutritional</p>	F 281	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.		

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F 281	<p>Continued From page 25 needs with current intake and stabilize weights.</p> <p>The next weight taken on Resident #86's after admission (2/9/13) was on 2/25/13 and recorded on the resident's "Weight Record" as 96.5 pounds. There was no assessments to determine why the resident's weight had dropped from 102.1 pounds on 2/9/13 to 96.5 pounds on 2/25/13. The resident was not re-weighed on 2/25/13 to determine if the weight taken was accurate. The resident's weight was not taken again until 3/27/13 where it was documented the resident weighed 103 pounds.</p> <p>The facility failed to re-weigh Resident #86 on 2/25/13 when the resident's weight was 96.5 a difference of 5.5 pounds from the resident admit weight on 2/9/13 of 102 pounds to determine if the weight taken on 2/25/13 was correct and to determine if the resident's nutritional plan of care should be revised. The facility did not notify the physician of the resident weight fluctuation and revise the resident plan of care until 3/18/13. These failures placed the resident at potential risk for not having his/her nutritional needs met.</p> <p>Refer to F280 Resident #86 for failure to revise nutritional care plan after a weight fluctuation.</p> <p>RESIDENT #171 Refer to F 314 and F 325 for medical history and additional information related to a [REDACTED] and weight loss.</p> <p>DIETARY FAXED REQUESTS Resident #171 admitted to the facility on [REDACTED]/13 and discharged on 4/16/13 to the hospital. During this admission a dietary consult conducted on</p>	F 281	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.		

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F 281	<p>Continued From page 26</p> <p>4/8/13 indicated Resident #171 lost weight. Staff J recommended to add additional calories and protein through an Every Bite Counts (EBC) diet and Resource Shake three times a day to the resident's diet.</p> <p>Resident #171 re-admitted to the facility on [REDACTED]/13. On 5/2/13 Staff J recommended addition of multivitamins and minerals to promote wound healing for the resident.</p> <p>During record review on 5/23/13, Resident # 171's medical record did not contain evidence staff followed through with dietary recommendations made on 4/8/13 and 5/2/13. Staff had not yet implemented the EBC diet, Resource Shake, Multivitamin and minerals or Vitamin C.</p> <p>On 5/23/13 at 11:04 a.m. Staff H reported dietary staff faxed dietary requests to physicians. Staff H also reported faxes that were confirmed sent successfully were placed in a team binder. Staff H also reported confirmed faxes in the team binder should remind nursing staff on the floor to follow up with the physician. Staff H looked in the team binder and did not locate a confirmed dietary request faxed on 4/8/13 for Resident #171.</p> <p>On 5/23/13 at 11:13 a.m. Dietary Staff J reported he/she did not always wait to confirm the fax was received by the physician's office.</p> <p>On 5/24/13 beginning 12:39 p.m. Staff Z reported when the physician signed the faxed request, nursing could begin implementation of dietary recommendations.</p>	F 281	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.		

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F 281	<p>Continued From page 27</p> <p>Nursing and Dietary staff failed to implement a system to ensure faxed recommendations to the physician for Resident #171 were timely confirmed received by the physician and timely follow up for response from the physician was completed.</p> <p>NURSING RECORD REVIEW FOR RE-ADMITTED RESIDENTS Recommendations for an EBC diet and Resource Shakes were made on 4/8/13, eight days before Resident #171 discharged to the hospital on 4/16/13. Staff failed to follow through with the physician regarding the recommendation prior to discharge.</p> <p>Resident #171 re-admitted to the facility on [REDACTED] 13. The record did not contain evidence licensed staff addressed incomplete follow up with the dietary recommendations made on [REDACTED] 13 when the resident re-admitted.</p> <p>Resident #171 discharged to the hospital on [REDACTED] 13. Prior to discharge, additional dietary recommendations were made on 5/2/13. When Resident #171 re-admitted for the third time on [REDACTED] 13, the record did not contain evidence nursing reviewed the second admission chart and identify dietary recommendations were still pending from 5/2/13.</p> <p>On 5/23/13, the surveyor informed nursing and dietary staff regarding incomplete follow up of dietary recommendations made during previous admissions. The facility obtained physician orders and implemented all dietary recommendations.</p>	F 281	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.		

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F 281	<p>Continued From page 28</p> <p>On 5/27/13 at 7:27 a.m. Staff B reported the admission nurse should review previous admission charts and look to see if any orders or recommendations were missed in current physician orders.</p> <p>RESIDENT #274 05/24/13 at 7:54 a.m. Resident #274 independently ate breakfast and consumed most of food including eggs, sausage and a huckleberry coffee cake.</p> <p>A registered dietitian (RD) nutritional assessment dated 05/15/13 identified Resident #274 was admitted on 05/13 with a weight of 122.9 pounds and a Body Mass Index (BMI) of 20.5 kilograms/m2. The RD recommended monitoring the resident's weights, labs and start multivitamins (MVI) with minerals to be added to the resident's plan of care.</p> <p>Review of Resident #274's medication administration record for May 2013 indicated the multivitamins were not started until 5/26/13.</p> <p>Refer to F280 Resident #274 for failure to implement registered dietitians recommendations in a timely manner.</p>	F 281		
F 314 SS=G	<p>483.25(c) PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and</p>	F 314	<p>F314: Resident #171 discharged on 5 Jun 13 and readmitted on 7 Jun 13. Facility assessed Resident #171's wound and has continued to assess weekly since readmission.</p> <p>Continued on Page 30 of 55</p>	

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F 314	<p>Continued From page 29 prevent new sores from developing.</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 comprehensive necessary care and services related to pressure ulcers for 2 of 3 Sampled Residents (#s 171 & 249) of the 45 residents who were included in the Stage 2 review. Failure to conduct ongoing pressure ulcer assessments and to follow physician prescribed pressure ulcer treatments for Resident #249 placed this resident at potential risk for a delay in pressure ulcer healing. Failure to fully investigate circumstances regarding ulcer development; develop a comprehensive care plan for prevention and to promote healing; timely inform the physician of the condition of the ulcer or implement all dietary recommendations resulted in harm for Resident #171.</p> <p>Findings include:</p> <p>RESIDENT #171 Resident #171's Minimum Data Set Assessments (MDS, a required assessment tool), identified the resident admitted to the facility three times. Resident admissions included time periods [REDACTED] 13 through 4/16/13; [REDACTED] 13 through 5/9/13 and current readmission on [REDACTED] 13. Twice, Resident #171 left the facility for hospitalizations due to medical complications.</p> <p>An admission MDS dated 2/26/13 identified the resident had diagnoses that included a [REDACTED], [REDACTED], and an [REDACTED]. The MDS</p>	F 314	<p>Continued from Page 29 of 55</p> <p>Measurements and condition of wound indicate healing. Resident #171 is on meal monitoring. Facility notified physician of Resident #171's nutritional status including weight, the status of her wound and requested to start Every Bite Counts (EBC). Resident #249 expired on 13 May 13.</p> <p>Facility has reviewed and updated it's system for faxing communication and recommendations to physicians and follow-up for timely implementation of care/treatment changes. Facility will review residents with pressure ulcers and/or at high risk for developing pressure ulcers to ensure measures are in place for the prevention and/or healing of pressure ulcers; a comprehensive care plan is in place including on-going assessment; and physician updates, recommendations and other related communication has occurred with follow-up as needed.</p> <p>Facility will review and update Policies & Procedures related to pressure sores and wound monitoring and in-service IDT.</p> <p>Facility will conduct weekly wound rounds to ensure measures are in place for the prevention and/or healing of pressure sores;</p> <p>Continued on Page 31 of 55</p>		

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F 314	<p>Continued From page 30 dated 2/26/13 and MDS assessment dated 4/27/13 both identified Resident #171 had cognitive impairment, disorganized thinking and could not participate in a complete mental status interview.</p> <p>ADMISSION #1 (2/19/13 - 4/16/13)</p> <p>An admission MDS dated 2/26/13 identified the resident did not have a pressure ulcer at the time of admission (2/19/13) and required extensive assistance from two staff for bed mobility, transfers and toileting and used a wheelchair. The MDS also identified the resident frequently had urine incontinence.</p> <p>A "Nursing Assessment" dated 2/19/13, identified on admission, Resident #171 had a red, blanchable painful area drawn on a picture of a human form across the [REDACTED]s. An assessment dated 2/19/13 identified the resident had risk factors for developing a pressure ulcer that included slightly limited sensory perception; occasionally moist; chairfast and limited mobility to make frequent changes to body position.</p> <p>A blanchable red area of skin turns white when pressed with a fingertip and then immediately returns to red when pressure is removed. Tissue exhibiting blanchable redness usually resumes normal color within a short period of time and often causes no long-term effects. However, the longer it takes for tissue to recover from finger pressure it could indicate a higher risk for developing pressure ulcers.</p> <p>A "Skin Impairment" form documented on 3/6/13, 16 days after admission, staff discovered</p>	F 314	<p>Continued from Page 30 of 55</p> <p>a comprehensive care plan is in place including on-going assessment; and physician updates, recommendations and other related communication has occurred with follow-up as needed. QA&A Committee will monitor compliance.</p> <p>Corrective action will be completed by 14 Jul 13.</p> <p>Director of Nursing and Administrator will ensure on-going compliance.</p>		

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F 314	<p>Continued From page 31</p> <p>Resident #171 had a 1.5 cm by 1.5 cm pink skin wound in the area of the left buttock. The next day, on 3/7/13, staff documented the wound as Stage II. A Stage II ulcer is loss of the skin surface which presents as a shallow open ulcer with red-pink wound bed. The form did not identify how staff classified the wound to identify if it was a pressure ulcer or if it had another type of wound origin.</p> <p>On 5/23/13 at 9:31 a.m. Staff G reported there should be a progress note that described the wound in more detail. When asked if the facility conducted investigations on ulcers that developed in the facility, Staff G reported "there would be a progress note." Staff G reported the Resident #171's skin wound was a pressure ulcer. The "Skin Impairment" form identified the ulcer resolved on 3/25/13.</p> <p>On 5/29/13 at 7:17 a.m., when asked to describe the investigation process the facility used when pressure ulcers developed in-house, Staff B reported it was discussed informally and not written down.</p> <p>No evidence was found in progress notes or in the record staff fully analyzed factors that may have contributed to development of Resident #171's pressure ulcer such as impact on the resident's skin tolerance while seated, type of wheelchair cushion and mattress used, frequency of current position changes to determine if increased frequency of re-positioning was needed for this resident, resident compliance with care or impact of moisture on the skin.</p> <p>On 3/28/13 (three days after the Skin Impairment</p>	F 314	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/30/2013
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NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE	STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370
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F 314	<p>Continued From page 32 form, dated 3/25/13, identified the ulcer as resolved), staff documented in the Skin Impairment form the resident developed another "red area" that measured 6.0 cm x 9.0 cm and 0.5 cm x 0.5 cm. The resident's record did not contain evidence staff identified the type or location of the red areas discovered, or assessed underlying conditions that may have led to its development. Resident #171's medical record did not contain evidence staff continued to monitor the second red areas.</p> <p>Resident #171's Care Plan did not identify interventions staff implemented to prevent development of the first Stage II pressure ulcer and to promote healing or measures taken to prevent re-development of a second red area/s after they documented the first Stage II pressure ulcer healed.</p> <p>The record did not contain evidence staff implemented dietary recommendations made on 4/8/13 for an Every Bite Counts (EBC) diet and Resource Supplement three times a day to fortify the resident's diet with additional calories and protein to promote healing.</p> <p>On 4/16/13 the resident discharged to the hospital.</p> <p>ADMISSION #2 ()/13 - ()/13)</p> <p>An interdisciplinary note dated ()/13 documented Resident #171 was readmitted to the facility on ()/13 following () for a () () The note indicated the resident had dementia and was alert only to self, was responsive but not able to follow directions.</p>	F 314	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</p>	
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F 314	<p>Continued From page 33</p> <p>The Admission MDS dated 4/27/13 identified the resident required total dependence from two staff for bed mobility, transfer, had a urinary catheter, frequent incontinence of bowels and used a wheelchair. The assessment identified the resident had risk factors for developing a pressure ulcer and did not have an ulcer at the time of the assessment.</p> <p>A "Nursing Assessment" conducted the day of admission, [REDACTED] 13 identified the resident had "red areas blanchable" noted and a picture of a human form that circled an area across the upper buttocks.</p> <p>A dietary assessment conducted five days later on 4/25/13 noted to request clarification of previous additions to the Resident's diet (made on [REDACTED] 13 during the first admission) to add additional calories, protein and fluids to ensure they were "added back in."</p> <p>Eight days following admission on 4/28/13, staff documented on a "Skin Impairment" form Resident #171 developed a 5.0 cm by 2.0 cm black bruise and 2.0 cm by 2.0 cm slough area identified as unstagable. Slough is tissue in a wound bed that is in the process from separating from the body. On 5/5/13 the form identified the wound increased in size and had a total size that measured 5.5 cm by 4.5 cm and an area of eschar that measured 3.0 cm by 1.0 cm. Eschar is a dark colored (black or brown) area of necrotic tissue.</p> <p>An MDS dated 5/7/13 classified the wound as an unstagable suspected deep tissue injury (SDTI).</p>	F 314	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.		

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F 314	<p>Continued From page 34</p> <p>The record did not contain an analysis when or how the resident may have developed an SDTI or why the facility determined the wound was a SDTI. The record did not identify prevention measures in place to attempt to minimize risks to prevent or promote healing of the unstageable wound that developed on 4/28/13, eight days after admission.</p> <p>On 5/23/13 at 10:28 a.m., when asked if staff completed a comprehensive assessment regarding the development of the ulcer, Staff H reviewed the resident's record and did not locate one.</p> <p>The facility plan of care did not identify Resident #171 had an SDTI and did not include specific interventions that were in place for ulcer prevention and to promote healing. A Resident Care Directive and a nursing note documented ten days after discovery of the unstagable ulcer, on 4/30/13, staff implemented an air mattress and updated the care plan to turn the resident every two hours side to side or bridge to keep pressure off the lower back.</p> <p>On 5/29/13 at 8:13 a.m. Staff E reported staff had turned Resident #171 every two hours according to the standard of care and was up in a Geri chair for meals. Staff E also reported when the resident did not eat staff offered protein shakes or other additional calories and should document protein shakes offered at meals on the medication record.</p> <p>The resident's care plan and "Resident Care Directive" did not identify for staff when, how often or for how long to get the resident up in a</p>	F 314	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.	

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F 314	<p>Continued From page 35</p> <p>Geri chair. No evidence was found in the record that identified how much Resident #171 ate or when staff offered Resident #171 protein shakes and how much the resident consumed.</p> <p>On 5/2/13 a dietary reassessment recommended dietary changes needed for wound healing. The reassessment note documented to continue with fortified dietary changes and add multi-vitamins and Vitamin C to aide with healing. No evidence was found staff implemented dietary interventions originally recommended on 4/8/13 for the EBC diet and Resource Supplement and did not follow through to ensure they were added back in when re-admitted on [REDACTED]/13. No evidence was found staff implemented dietary recommendations for multi-vitamins and Vitamin C recommended on 5/2/13.</p> <p>On 5/27/13 at 7:27 a.m. Staff B reported the nurse who admitted the resident (on 4/20/13) should review the chart from the previous admission to see if any orders from the prior admission needed to be added to current orders.</p> <p>On 5/9/13 Resident #171 returned to the hospital due to [REDACTED]</p> <p>THIRD ADMISSION (5/16/13 TO PRESENT)</p> <p>Resident #171 readmitted to the facility on [REDACTED] 13. A "Skin Impairment" form identified the resident readmitted with a pressure ulcer on the [REDACTED]. Notes indicated the ulcer had a black center, white edges and the surrounding area was red and blanched. The form did not identify the stage of the ulcer. The column to identify the stage documented "pending" or</p>	F 314	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</p>	

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F 314	<p>Continued From page 36 "unable to assess".</p> <p>On 5/23/13 beginning 8:57 a.m. Staff H changed the resident's dressing with Staff G present. While turned on the right side Staff H removed the dressing to the wound. Staff H reported the wound measured approximately 4.5 cm by 2.5 cm. The wound bed contained slough and black eschar in the center of the wound.</p> <p>On 5/29/13 at 1:30 p.m. during a second observation of dressing change, Staff H palpated the area surrounding the wound bed and reported the area beneath the ulcer felt hard, like bone.</p> <p>A significant change MDS Care Area Assessment (CAA) titled "Pressure Ulcer" dated 5/23/13 documented the facility identified Resident #171 admitted with an SDTI to the [REDACTED] area. The CAA identified interventions implemented included a wheelchair cushion, turning and positioning to avoid time on [REDACTED] pressure relief mattress and dietary consult and received cueing and assistance for poor food intake and supplemental shakes when intake was poor at meals.</p> <p>Resident #171's record did not contain evidence staff monitored food intake, identified when they offered health shake supplementation and resident response.</p> <p>On 5/23/13, Staff J reassessed the resident's dietary need. A dietary note documented the resident lost a total of 11.7 lbs. or 8.3% of body weight between 2/25/13 and 5/17/13. This timeframe included Resident #171's three admissions and two hospitalizations. The note</p>	F 314	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.		

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F 314	<p>Continued From page 37</p> <p>stated to re-fax requests to the physician to implement previously made recommendations for multivitamins and minerals, Vitamin C, Resource Shakes and to add a trial of an additional protein supplement. The dietary note identified the resident ate poorly at meals and would benefit from the most caloric and protein dense foods and calculated needs to promote wound healing and to help regain lost weight.</p> <p>The May 3013 Medication Record (MAR) identified staff did not initiate administration of the Resource Shake (originally recommended on [REDACTED]/13 during the first admission) until [REDACTED]/13 during the third admission. The May 2013 MAR also identified multivitamins and Vitamin C (initially recommended on [REDACTED]/13 during the second admission) were not initiated until [REDACTED]/13, nine days later after the resident re-admitted the third time.</p> <p>On 5/23/13 at 11:50 a.m. when asked how important the EBC diet and Resource Shake was for Resident #171's wound healing, Staff J reported they were "very important" for healing. Staff J reported the Resource Shake provided additional protein.</p> <p>SUMMARY</p> <p>During the first admission the facility failed to conduct a thorough assessment/investigation that identified the type of wound Resident #171 developed or circumstances that may have led to the development of a [REDACTED]. The facility also failed to develop a comprehensive careplan and implement all prevention measures to prevent a blanchable reddened area from</p>	F 314	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.		

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F 314	<p>Continued From page 38</p> <p>developing into a pressure ulcer and did not maintain consistent monitoring of two red areas identified on 3/28/13 that re-developed after the facility documented the ulcer healed. The facility failed to timely follow up with dietary recommendations made when the facility identified weight loss occurred.</p> <p>When Resident #171 re-admitted to the facility on [REDACTED]/13 and [REDACTED]/13, staff did not develop a comprehensive plan of care to prevent re-occurrence of a pressure ulcer although Resident #171 was determined high risk for it to reoccur. Staff also did not provide evidence they timely informed the physician of worsening of the condition of the ulcer when staff identified it unstagable on 5/5/13.</p> <p>At the time of subsequent re-admissions the facility also failed to review previous dietary recommendations and timely initiate follow up for implementation for nutritional support to promote healing of an ulcer.</p> <p>The record did not contain evidence staff consistently monitored Resident #171's food intake and health shake supplementation provided when meals were not consumed. Nutritional interventions to promote wound healing were not timely implemented in the facility during all three admissions and did not get implemented until nine days after Resident #171 admitted the third time.</p> <p>Failure to not provide all necessary care and services and interventions Resident #171 needed to attempt to prevent the development and re-occurrence of an ulcer or to promote healing of</p>	F 314	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.		

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F 314	<p>Continued From page 39</p> <p>an unstagable pressure ulcer constituted harm for this resident.</p> <p>Refer to F 157 for failure to fully inform the physician Refer to F 280 for failure to develop a comprehensive plan of care Refer to F 281 for failure to follow through with dietary recommendations Refer to F 325 for failure to timely implement dietary recommendations</p> <p>RESIDENT #249 Former Resident #249 was admitted to the facility with diagnosis of [REDACTED] among others on [REDACTED]/13 and [REDACTED] on [REDACTED]/13.</p> <p>Review of Resident #249's Admission Minimum Data Set (MDS), dated 2/28/13, noted the resident developed a [REDACTED] after admission to the facility. This MDS identified the resident as being at high risk for pressure ulcer development and a care plan was developed.</p> <p>On 5/24/13 at 11:06 a.m. Staff C, who completed the Resident #249's Admission MDS dated 2/28/13, reported the resident's [REDACTED] pressure ulcer was developed after admission to the facility on 2/21/13.</p> <p>Review of a form titled: "Skin Impairment", used by the facility to document weekly assessments of Resident #249's pressure ulcer, noted the first entry on the form was dated 2/26/13 identifying a Stage II pressure ulcer with length/width 0.4</p>	F 314	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.		

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F 314

Continued From page 40
centimeters (cm) x 0.4 cm; no depth; no drainage; pink wound color; no odor; no tunneling. A small circle was drawn on the upper inner [REDACTED] area of a body outline contained on the form indicating the site of the wound. The second and last entry on this form was dated 3/29/13 which indicated the resident's wound was "Discontinued-Resolved".

A physician's order dated 2/26/13, the same day the resident's pressure ulcer was first identified, directed staff to start [REDACTED] a prescribed treatment, to the resident's [REDACTED] QOD (every other day) and as needed (prn).

Review of the resident's March 2013 medication administration record noted the prescribed treatment [REDACTED] was not consistently changed QOD as ordered by the physician.

Further review of former Resident #249's record noted no ongoing assessments of the resident's [REDACTED] pressure ulcer after it was first discovered on 2/26/13 and no assessments of the effectiveness of the prescribed [REDACTED] treatment since [REDACTED] had not been applied every other day and as needed during the month of March 2013. The only other documentation of the resident's Stage 2 pressure ulcer was on 3/29/13 where a note "Discontinued-Resolved" was written onto the resident's "Skin Impairment" record.

On 5/24/13 at during a meeting starting at 1:30 p.m. with the survey team, Staff D and Staff E were briefed that former Resident #249 was identified on 2/26/13 as having a [REDACTED]

F 314

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F 314	<p>Continued From page 41</p> <p>pressure ulcer with no other documentation in the record until 3/29/13 when Staff D documented the resident pressure was healed. Staff D reported she/he would check the resident's record.</p> <p>On 5/28/13 at 11:13 a.m. Staff D did not provide additional documentation of ongoing assessments of former Resident #249's [REDACTED]. At this interview, the surveyor reviewed the resident's March 2013 treatment record which showed the prescribed treatment of [REDACTED] was applied on a prn basis not on a every other day basis and prn as ordered by the physician. Staff D agreed the orders for [REDACTED] were ordered by the physician to be done QOD and prn.</p> <p>On 5/30/13 at approximately 2:15 p.m. during the exit conference Staff A and Staff B did not provide further evidence regarding the care of Resident #249's Stage 2 [REDACTED].</p> <p>The facility initially identified Resident #249's [REDACTED] ulcer on 2/26/13 and obtained a prescribed treatment on the same day. After the initial assessment of the resident's Stage 2 pressure ulcer on 2/26/13, the facility failed to conduct ongoing assessments of the resident's [REDACTED] ulcer to determine if the resident's [REDACTED] had worsened. In addition, the facility failed to provide prescribed physician pressure ulcer treatments (Allevyn) as ordered during the month of March 2013 and failed to assess whether or not [REDACTED] treatments promoted prompt healing of the resident's [REDACTED]. The only other documentation of the resident's Stage [REDACTED] was on 3/29/13 where</p>	F 314	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</p>	

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F 323	Continued From page 43 [REDACTED] cream. On 5/23/13 at 6:48 a.m., 11:57 a.m. and 12:30 p.m., the treatment cart was observed unlocked and unattended in the same location as on 5/22/13. On 5/23/13 at 12:42 p.m., during an interview, Staff V, a licensed nurse, stated the treatment cart did not need to be locked and it was always kept unlocked in the hallway. On 5/23/13 at 1:26 p.m., during an interview, Staff T, the unit manager, stated his/her expectation was the treatment cart must be kept locked when not in use. Staff T stated that multiple cognitively impaired residents mobilized independently on the unit and the treatment cart contained materials that were potentially hazardous to residents.	F 323			
F 325 SS=D	483.25(i)(1) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to consistently conduct weekly weights as care planned, timely re-weigh or implement nutritional interventions to assist with prevention of further weight loss and promote wound healing for 1 of 3	F 325	F325: Resident #171's weight and nutritional status was reviewed. Facility ensured nutritional recommendations were in place and care plan was updated with interventions for weight loss prevention. Facility will review resident weights to ensure timely re-weighs were completed and nutritional interventions are in place to prevent further weight loss and promote wound healing if indicated. Facility will review and update <i>Weights Policy & Procedure</i> to include clarification regarding assessment and interventions when weight variances are identified and will in-service IDT. Facility will conduct monthly weight audits to ensure compliance with <i>Weights Policy & Procedure</i> and that nutritional interventions are in place. Discrepancies will be immediately corrected. QA&A Committee will monitor compliance. Corrective action will be completed by 14 Jul 13. Director of Nursing and Administrator will ensure on-going compliance.		

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F 325	<p>Continued From page 44</p> <p>Sampled Residents (#171) reviewed for weight loss of the 45 residents who were included in the Stage 2 review. These failures had the potential for Resident #171 to experience unnecessary weight loss and/or impair healing of an ulcer.</p> <p>Findings include:</p> <p>Refer to F 314 for additional medical history, observations and information related to a pressure ulcer for Resident #171.</p> <p>FIRST ADMISSION Resident #71 admitted to the facility on [REDACTED]/13 following surgery for a [REDACTED]. On 2/25/13 staff documented the resident weighed 141.6 pounds (lbs). Staff documented the following week on 3/4/13, the resident lost 3.9 lbs and weighed 137.7 lbs. The weight record documented staff did not weigh the resident again until 3/22/13, 19 days later.</p> <p>A plan of care located in the resident's record included a problem area titled "Altered Nutrition Status." Approaches included for staff to obtain weekly weights starting 3/7/13. Staff did not record they weighed the resident weekly as care planned between 3/4/13 and 3/22/13.</p> <p>On 4/4/13 staff documented the resident weighed 133.2, and lost 8.4 lbs. or 5.9 % of body weight since admission over the previous five and a half weeks.</p> <p>On 4/8/13, a dietary referral for weight loss conducted documented the resident reported he/she eats everything and noted the resident ate "bites only." The consult indicated the resident</p>	F 325	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.		

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F 325	<p>Continued From page 45</p> <p>lost weight due to decreased intake and recommended addition of an Every Bite Counts (EBC) diet to increase calories and 60 ml of Resource Shake with medpass three times a day.</p> <p>The facility Policy and Procedure for EBC indicated the EBC diet added additional calories and protein to the diet. The policy identified residents who were at nutritional risk due to weight loss, low albumin (blood protein level) and open areas would be placed on the EBC meal fortified diet. The resident had an open area and staff treated Resident #171 for a Stage II pressure ulcer between 3/6/13 and 3/25/13.</p> <p>The record did not contain evidence staff weighed the resident following weight loss identified on 4/4/13 until 4/16/13 to determine if the resident's weight continued to trend downward and additional interventions were needed. The resident's record did not contain evidence staff followed through and implemented the dietary recommendations made on 4/8/13 before Resident #171 discharged to the hospital eight days later on 4/16/13.</p> <p>SECOND ADMISSION Resident #171 re-admitted to the facility following hospitalization on [REDACTED]/13.</p> <p>A dietary note dated 4/23/13 documented the resident re-admitted following a [REDACTED] and the resident had blanchable redness on the [REDACTED]</p> <p>A dietary note dated 4/25/13 noted prior recommendations on 4/8/13 were made for an EBC diet and Resource three times a day. The</p>	F 325	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.	

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F 325	<p>Continued From page 46</p> <p>note stated "will request clarification" that additional calories, protein and fluids were re-added back in.</p> <p>A later dietary note dated 5/2/13 identified the resident had treatment for an [REDACTED] wound and had new estimated needs for wound healing. The dietary note identified the resident had an EBC diet, to continue with Resource supplementation and to add multivitamins and minerals and Vitamin C to promote healing.</p> <p>Resident #171's record did not contain evidence staff implemented recommendations for the EBC diet, Resource Shake during the second admission that were made earlier on 4/8/13. The record did not contain evidence staff implemented recommendations for vitamin supplementation made on 5/2/13 before the resident again was re-hospitalized on 5/9/13.</p> <p>On 5/27/13 at 7:27 a.m. Staff B reported nursing staff should have reviewed the previous admission chart for prior orders and recommendations. Staff B confirmed the previous admission records needed to be pulled forward for staff to review when residents go in and out to the hospital.</p> <p>THIRD ADMISSION Resident #171 re-admitted back to the facility on [REDACTED] 13 following hospitalization.</p> <p>A readmission dietary note dated 5/20/13 documented Resident #171 weighed 129.9 lbs. upon re-admission and had weight loss of 5% during the past month. The note also identified the resident had diarrhea and an open area.</p>	F 325	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</p>	

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F 325	<p>Continued From page 47</p> <p>On 5/23/13 at 11:50 a.m. Staff J reviewed all dietary recommendations that were made for Resident #171 during all three admissions with the surveyor. When asked if the resident received the EBC diet (recommended 4/8/13), Staff J went to the kitchen to pull the diet card. Staff J returned and reported the resident did not receive an EBC diet. Staff J also reported the Resource Shake provided additional protein and both the Resource and EBC diet were "very important" for healing the resident's wound.</p> <p>Staff J also reported he/she thought the Resource and EBC diet had been ordered following the original recommendation (4/8/13).</p> <p>A wound and weight assessment dated 5/23/13 documented Resident #171 had a low protein blood level. The note identified a fax was re-sent to the physician to request multivitamins with minerals and Vitamin C (initially recommended on 5/2/13 during the second admission). The note also requested to increase the original amount of the Resource Shake (requested initially 4/8/13) from 60 ml to 120 ml three times a day.</p> <p>Review of February 2013, March 2013 and May 2013 Medication Records identified staff did not implement dietary recommendations for Resource, multivitamins and minerals or Vitamin C until 5/24/13. All three recommendations were not timely implemented.</p> <p>A plan of care located in the resident's record on 5/23/13 identified a problem area titled "Altered Nutrition Status." Approaches included to offer meal replacement if eats less than 50%; perform</p>	F 325	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.		

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F 325	<p>Continued From page 48</p> <p>weekly weights as of 3/7/13 and assess likes and dislikes. The plan of care did not contain any updated interventions for weight loss prevention.</p> <p>During an interview on 5/23/13 at 1:38 p.m. Staff J reviewed Resident #171's record and did not locate evidence the nutrition plan of care contained updated interventions for weight loss prevention.</p> <p>On 5/23/13 at 12:50 p.m. Resident #171 sat in the dining room and received encouragement to eat from staff. The resident stated "I'm not hungry". The resident did not eat food on the plate and only drank liquid from a fruit cup and ate ice cream cup offered by staff.</p> <p>On 5/29/13 at 12:50 p.m. Resident #171 did not eat any of the main noon meal. Staff O reported if the resident did not eat 50% of the meal she would tell the nurse who would decide if staff should offer a health shake. Staff O reported staff did not document monitoring of food intake.</p> <p>During all three admissions between 2/19/13 through 5/29/13, staff did not consistently monitor how much food Resident #171 ate on a regular basis, if an alternate meal or health shakes were offered or the resident's response to shake supplementation staff reported they provided to have consistent information across multiple shifts to determine what nutritional interventions were effective or if new approaches were needed to delay further weight loss.</p> <p>On 5/23/13 at 11:04 a.m., Staff J reported he/she relied on staff verbally reporting how much food intake a resident had and also on resident</p>	F 325	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.		

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F 325	Continued From page 49 interviews. On 5/29/13 at 1:20 p.m. Staff P reported food monitor records were discontinued since they were completed inaccurately or not completely. The facility failed to update the plan of care, consistently monitor food intake and response to health shakes staff reported they provided when meals were not consumed or timely implement all additional nutritional interventions needed to promote wound healing and attempt to slow or prevent further weight loss for Resident #171. Refer to F 314 for failure to provide comprehensive pressure ulcer services. Refer to F 280 for failure to update nutritional plan of care.	F 325			
F 327 SS=D	483.25(j) HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to timely reassess hydration needs and monitor hydration status to ensure all measures were in place to provide adequate hydration and timely identify dehydration onset for 1 of 3 Sampled Residents (#158) reviewed for dehydration of the 45 residents who were included in the Stage 2 review. This had the potential to prevent staff from initiating interventions timely to prevent reoccurrence of dehydration.	F 327	F327: Resident #158 expired on 12 May 13. Facility will reassess residents for hydration needs and monitoring and will update care plans as appropriate. Facility will review and update Policy & Procedure regarding assessing and monitoring resident hydration needs and in-service IDT. Facility will conduct monthly audits of resident records to ensure hydration needs and monitoring are addressed as needed. QA&A Committee will monitor compliance and follow-up as needed. Corrective action will be completed by 14 Jul 13. Director of Nursing and Administrator will ensure on-going compliance.		

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F 327	Continued From page 50 Findings include: Resident #158 admitted to the facility on [REDACTED]/13. A Nutrition Review dated [REDACTED]/13 identified the resident had [REDACTED], an [REDACTED], [REDACTED] and a [REDACTED]. An [REDACTED] is an opening in the [REDACTED] that brings the end loop of the small intestine to the surface of the skin. [REDACTED] is collected into a [REDACTED] to the abdomen. The review calculated the resident needed 2250 ml of fluids a day. A care plan dated 4/14/13 for "Alteration in Nutrition" identified the resident had poor oral intake of food and fluids. A care plan for "Dehydration" with a start date of 4/17/13 included an approach to assess/record/report to MD signs and symptoms of dehydration. A 5 day Minimum Data Set (MDS, assessment tool) dated 4/19/13 identified the resident had incontinence, required supervision to eat and did not identify the resident had dehydration at that time. A nursing note dated 4/20/13 through 4/22/13 documented the resident had increased drainage from the ileostomy and on 4/22/13 noted stools were "watery." Nursing notes documented the facility sent the resident to the emergency room (ER) on 4/22/13 due to a critical lab value. When the resident returned to the facility the same day, nursing notes documented the resident had a diagnosis of dehydration and received intravenous (IV) fluids in the ER. A nursing note dated 4/23/13 documented upon	F 327	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.		

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F 327	<p>Continued From page 51</p> <p>return from the ER, Resident #158 also had a diagnosis of [REDACTED]. Notes written between 4/23/13 and 4/24/13 documented the resident drained liquid stool from the [REDACTED], ate little and staff encouraged fluids.</p> <p>On 4/24/13 the physician ordered administration of 2000 ml of additional IV fluids; insertion of a urinary catheter into Resident #158's bladder for three weeks and administration of a diuretic for seven days.</p> <p>Nursing notes documented IV fluids were finished during the night shift on 4/26/13. Notes also documented between day shift 4/27/13 and 5/4/13 Resident #158's [REDACTED] drained liquid [REDACTED] intermittently and [REDACTED] drained [REDACTED]. On 5/5/13 the physician ordered additional IV fluids.</p> <p>Following Resident #158's diagnosis of [REDACTED], history of an [REDACTED] [REDACTED], IV administration and [REDACTED], the resident's medical record did not contain evidence staff monitored and conducted ongoing comprehensive reassessment of the resident's hydration status to ensure continued adequate oral fluid intake or urine output.</p> <p>The record did not contain evidence staff timely referred the resident for a dietary reassessment to identify if additional dietary and fluid recommendations were needed. Resident #158's record identified a dietary reassessment did not occur until 5/9/13, after the resident received additional IV fluids on 5/5/13.</p> <p>On 5/28/13 at 9:54 a.m. Staff D reported staff</p>	F 327	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</p>	

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

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F 327	Continued From page 52 should monitor residents with dehydration and maintain a record of intake and output and the night nurse should total the amounts consumed to ensure the resident took enough fluids in. Staff D reviewed Resident #158's medical record and reported the record did not identify staff monitored for dehydration and notes just mentioned staff offered fluids. Staff D reported the meal monitor did not identify how the resident drank during meals. Staff D also reported residents with dehydration were usually referred for a dietary consult to ensure specific fluid needs were adequate to hydrate. On 5/28/13 at 12:45 p.m. Staff AA also reported staff should have monitored intake and output for Resident #158 and review total amounts every 24 hours and monitor for specific signs of dehydration because the resident had a [REDACTED] and IVs. The facility failed to reassess and identify fluid needs for Resident #158 following diagnosis of dehydration requiring IV fluids. The facility also failed to maintain close monitoring and reassessment of the resident 's hydration status to assure they could timely identify a decline in hydration status and timely intervene.	F 327			
F 329 SS=D	Refer to F 280 for failure to update Resident #158's care plan. 483.25(l)(1) 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	F 329	F329: Resident #130 discharged 22 Jun 13. Facility will review residents to ensure their drug regimen is free of unnecessary drugs including excessive doses, excessive duration, inadequate monitoring and/or inadequate indications for use. Continued on Page 54 of 55		

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F 329	<p>Continued From page 53</p> <p>indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review it was determined the facility failed to monitor the effectiveness of a [REDACTED] medication used for sleep for 1 of 10 Sampled Residents (#130) reviewed for unnecessary medications of the 45 residents who were included in the Stage 2 review. This failure placed Resident #130 at potential risk for receiving an unnecessary medication. Findings include: On 05/21/2013 at 10:25 a.m. Resident #130, who was alert and interactive, was seated in wheelchair in room watching television.</p> <p>A physician order dated 05/05/2013 directed staff to administer [REDACTED], a [REDACTED], to help the resident sleep at night.</p> <p>Review of medication administration record from 5/2/2013 through 5/23/13 showed Resident #130 received [REDACTED] every night between May 2, 2013 and May 22, 2013 but there was no monitoring of this medication to determine if it was effective in helping the resident sleep at night.</p> <p>Review of Resident #130's progress notes between 5/2/2013 and 5/23/13 noted no documentation of the effectiveness of [REDACTED] in helping the resident sleep at night.</p>	F 329	<p>Continued from Page 53 of 55</p> <p>Facility will review and update Policy & Procedure related to assessing and monitoring the use of hypnotic and other psychoactive medications and will in-service licensed nurses.</p> <p>Facility will conduct monthly resident record audits to ensure resident drug regimens are appropriate including proper dose, duration, monitoring, indications for use and effectiveness. Discrepancies will be immediately corrected. QA&A Committee will monitor compliance.</p> <p>Corrective action will be completed by 14 Jul 13.</p>		

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F 329	<p>Continued From page 54</p> <p>On 5/28/13 at approximately 1:50 p.m. both Staff F and Staff E reported documentation of the effectiveness of Resident #130's [REDACTED] would be on the resident's medication administration record or in the resident's progress notes.</p> <p>The facility failed to monitor the effectiveness of Resident #130's [REDACTED] to determine if it was effective in helping the sleep at night. This failure placed the resident at risk for receiving an unnecessary medication.</p>	F 329	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</p>	