04/14/14 - MFCU/Ombud/MC & -CO

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

PRINTED: 03/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	505361		03/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICANA HEALTH & REHAB CTR	917 7TH AVENUE LONGVIEW, WA 98632

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This report is the result of an unannounced Quality Indicator Survey conducted at Americana Health and Rehabilitation Center on 03/16/14, 03/17/14, 03/18/14, 03/19/14, 03/20/14 and 03/21/14 and includes on off hours entry on 03/16/14 at 2:20 p.m. A sample of 37 residents was selected from a census of 50. The sample included 32 current residents and the record of 5 former and/or discharged resident. The survey was conducted by: Shelly Darnell, BSS Marie Rose, RN, MN Sandy Mayes, RN, BSN Candice Mohar, PhD, RN, MSN The survey team is from: Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, District 3, Unit D 6639 Capitol Boulevard SW P.O. Box 45819 Tumwater, Washington 98504-5819 Telephone: 360.664.8420 Fax: 360.664.8451 3/28/14 Residential Care Services Date	F 000	**Preparation and/or execution of this plan of correction does not constitute the provider's admission of or agreement with 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 provisions of federal and state law.** RECEIVED APR 14 2014 DSHS/ADSA/RCS	5/19/14

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 4/11/14

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	Resident #46 has been re-interviewed with regards to this incident. The findings have been documented on appropriate incident forms and placed on the incident log as a late entry Investigation has been completed and documented in a thorough manner, by the state guide lines to attempt to rule out or substantiate abuse. Results of this investigation have been reported to the state hot line. Residents will be protected from abuse, neglect, and mistreatment through thorough investigations of allegations made by residents or their representatives. These allegations will be reported to the State, the Administrator and any other agencies required in a timely manner and by following the guide lines set out by the State. The Director of Nursing Services has been re-educated on following the State guidelines for the investigation and reporting of abuse, neglect or mistreatment. The Administrator or her designee will now be responsible for the investigation and reporting of allegation of abuse, neglect or mistreatment. Incidents, including allegations of abuse, neglect or mistreatment will be reviewed in team meetings to ensure appropriate follow up and investigations are completed and reported as needed. Incident logs will be audited and results of these audits reviewed in Quality Assurance meetings to maintain compliance.	

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F 225	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to conduct timely and thorough investigations and report to the state agency in accordance with state law and 42 CFR 483.13(c)(3) alleged violations to rule out mistreatment of a resident and to protect and prevent further similar incidents for 1 of 20 current sampled residents (#46) reviewed for abuse. This failure to report and conduct thorough investigations prevented the facility from ruling out abuse of the resident and placed Resident #46 and other residents at risk for further mistreatment and psychological harm. Findings include: On 3/17/14 at 10:32 a.m., Resident #46 told the surveyor that two direct care staff had yelled at her on different occasions and were sometimes rough with her, causing her to say "ow" during transfers, which the resident thought might be intentional. The resident said she did not report it to anyone and did not wish to identify the staff or provide other additional information to the surveyor due to fear of retaliation from direct care staff. On 3/17/14 at 5:36 p.m., the surveyor reported Resident #46's allegation to the Director of Nursing Services (DNS). The DNS stated there had been multiple occasions when direct care staff told the DNS that Resident #46 said facility staff were mistreating her. The DNS said each time she asked Resident #46 about the allegations, the resident denied making any allegations.	F 225		

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F 225	Continued From page 3 The DNS stated she "investigated" the allegations but never called the state agency: the Complaint Resolution Unit (CRU). Review of facility incident logs from September 2013 through March 2014 revealed no incidents of Resident #46 alleging mistreatment or abuse. On 3/20/14 at 6:49 p.m., the DNS stated that when she said she "investigated" the allegations, she meant that she asked Resident #46 about them. The DNS said even though direct care staff told the DNS that Resident #46 said they mistreated her on multiple occasions, the DNS did not fill out incident reports, conduct investigations or report allegations to the CRU. When asked to describe examples of instances in which staff told her Resident #46 alleged mistreatment, the DNS said it was hard to remember but recalled a recent occasion when Nursing Assistant (NA) G said Resident #46 accused NA G of yelling at or being rude to the resident. On 3/20/14 at 6:58 p.m., with the DNS present, NA G stated that approximately two weeks ago, on the evening shift, Resident #46 told NA G that NA G was "rude" to the resident, "used a mean, manly voice" and talked to the resident "like she was a dog." NA G said Resident #46 said, "Don't talk to me like a dog. I could have you fired." The DNS confirmed that NA G reported the incident to the DNS on the evening it occurred and said when the DNS asked Resident #46 about it, the resident denied making any such comments to NA G. The DNS said she did not think the incident warranted a call to the CRU or	F 225		

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F 225	Continued From page 4 an investigation beyond verbally asking the resident about the allegation. The DNS stated she did not document the incident in any facility records. The facility failed to conduct timely and thorough investigations and report to the state agency alleged violations to rule out mistreatment of Resident #46 and to protect and prevent further similar incidents. This failure prevented the facility from ruling out abuse of the resident and placed Resident #46 and other residents at risk for further mistreatment and psychological harm.	F 225		
F 240 SS=E	483.15 CARE AND ENVIRONMENT PROMOTES QUALITY OF LIFE A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure the environment was free of cigarette smoke odor in 1 of 2 dining rooms (Lakeside) during meals and resident group activities. This failure placed residents at risk for decreased quality of life and increased negative health conditions due to the extensive, repeated and daily secondhand smoke lingering in their indoor living and outdoor recreational environments.	F 240	Residents were exposed to second hand smoke. The facility will relocate the smoking area to prevent exposure of resident to second hand smoke. Residents will be protected from weather elements while smoking. Administrator will meet with Resident Council to discuss new smoking area and receive their input. Staff will be re-educated on smoking policy and smoking changes. Monthly audit of smoking activities will be completed by the Administrator and any concerns found will be presented to the Quality Assurance Team until substantial compliance is met and maintained.	

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F 240	Continued From page 5 Findings include: "Facilities are obligated to ensure the safety of designated smoking areas including protecting residents from weather conditions and non-smoking residents from secondhand smoke" (NH #2011-021 Dear Administrator letter). "...Smoking is prohibited within twenty-five feet of public places...to include nursing homes...from entrances, exits, windows that open, ventilation intakes..."(Chapter 70.160.020 (2)(3) RCW). "...exposure to secondhand smoke is known to cause cancer...other diseases including pneumonia, asthma, bronchitis and heart disease...likely to develop chronic, potentially fatal diseases as a result of such exposure" (Chapter 70.160.011 RCW). The outdoor courtyard was for all residents' enjoyment. Those who smoked followed scheduled smoking times every two hours at 9:00 a.m.,11:00 a.m.,1:00 p.m., 3:00 p.m., 5:00 p.m. and 7:00 p.m., preventing other residents, who chose not to be in a smoke-filled environment, access to the courtyard at these times. Resident rooms, Lakeside dining room and the conference room, all with windows that opened, surrounded the courtyard. During observations of activities in the Lakeside dining room on 03/17/14 at 1:15 p.m., a strong odor of cigarette smoke was noted. Residents who smoked entered and exited through the Lakeside dining room as it was the only way to access the courtyard. Seven residents were observed in the courtyard	F 240		

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F 240	Continued From page 6 smoking while three residents were in the Lakeside dining room waiting for a group activity to start. The smoke odor filled the dining and conference room even when windows were closed. Residents had no weather protection and sat under the eaves, close to the walls and windows of the facility, surrounding the courtyard. Two residents were smoking about two feet from the door. During the 15 minute scheduled smoking period, the door to the smoking area opened and closed several times. The door was activated by an electronic entrance push button which held the doors open for approximately 15 seconds. Each time anyone exited and entered the facility, the smoke odor in the room was more evident. The Activity Director also opened the door twice to ask residents if they would like to come in and join the 1:00 p.m. scheduled activity in the adjoining Lakeside dining room. When interviewed, she stated it was hard to get people to activities and agreed it might be due to smoking schedule conflicts. The conference room windows, overlooking the courtyard, were closed by surveyors during scheduled smoking times because of the strong smell of secondhand smoke coming into the room. Even with windows closed, the smoke odor permeated the room. Failure to ensure all residents and their visitors could use the courtyard when they pleased and to ensure residents were protected from secondhand smoke in their living and recreational	F 240		

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F 240	Continued From page 7 environments, created the potential for loss of enjoyment, decreased quality of life and increased health issues. Refer to F 465.	F 240		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to promote care for residents in a manner that maintains or enhances each resident's dignity and respect for 4 of 6 current sampled residents (#s 32, 30, 20 & 36) reviewed for dignity when staff fed Resident #32 in a hurried manner while standing over the resident and without interacting with the resident, and when staff told Residents #20 and #36 they could not have coffee while they waited for breakfast in the dining room. These failures placed residents at risk for diminished self-esteem and diminished quality of life. Findings include: <Resident #32> Resident #32 was readmitted to the facility on [redacted]13 with diagnoses to include stroke,	F 241	Resident # 32 will be assisted during dinning as needed in an appropriate manner that maintains her dignity. Residents #30, #20 and #36 will have access to a coffee station. Residents will be assisted in dinning as needed in a manner that preserves and promotes their dignity. Residents will be provided coffee from coffee station independently or upon request. Licensed Nursing Staff will receive re-education on appropriate techniques for assisting residents in with meal and hydration availability. Coffee, Tea and hot water station will be set up for easy access for the residents. The dining process will be periodically monitored by management staff. The dinning process and coffee station will be audited for correct meal assistance and coffee station availability to maintain resident dignity. Any issues brought noted on audits will be addressed by the Administrator and the Director of Nursing in a timely manner and reviewed in the Quality Assurance Team Meetings until compliance is met and maintained.	

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F 241	Continued From page 8 swallowing dysfunction and a [redacted] disorder. The Minimum Date Set (MDS), an assessment tool, dated 3/13/14, indicated Resident #32 had limited ability to communicate verbally. The resident required extensive assistance with activities of daily living, including eating. On 3/16/14 Resident #32 was observed during dinner in the Lakeside (assisted) dining room. At 5:54 p.m., the resident was served a meal of pureed ravioli on a plate and thickened liquids in cups. The resident fed herself the liquids but struggled with the pureed food on the plate. The resident smiled and interacted with the three other residents seated at her table. At 6:05 p.m., Licensed Nurse A began feeding Resident #32 the pureed food while standing over the resident. LN A used a large spoon and fed large mouthfuls to the resident. LN A held each new spoonful of food approximately 5-6 inches from the resident's face as the resident chewed, putting a new spoonful in the resident's mouth as soon as the resident swallowed the previous bite. Resident #32 grimaced, coughed and drooled excessively throughout the feeding. LN A did not wipe away the resident's secretions, give the resident time to clear her throat or ask the resident if she was ready for another bite before putting more food in the resident's mouth. LN A interacted with other residents seated at the table but did not interact with Resident #32. This continued for 8-9 minutes until all the food on Resident #32's plate was gone. On 3/20/14 at 12:31 p.m., LN B was observed	F 241		

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F 241	Continued From page 9 feeding lunch to Resident #32 in the Lakeside dining room. LN B sat in a chair close to the resident, facing the resident. LN B gently wiped drool from the resident's mouth, gave the resident long breaks between bites, asking if the resident was ready for another bite or if she need to clear her throat before putting more food in the resident's mouth. LN B engaged in friendly conversation with the resident. Resident #32 smiled and appeared to enjoy the interaction with LN B. On 3/20/14 at 12:46 p.m., LN B stated that Resident #32 had excess saliva and often choked on her food. LN B said facility staff were trained by the speech therapist to always ask Resident #32 if she is ready for a bite before giving her one and to ask her if she needs to clear her throat. LN B said that on 3/16/13 she observed LN A standing over Resident #32 as she fed the resident her dinner. LN B said she offered LN A a chair but LN A declined and continued standing as she fed the resident. LN B said when the meal was finished LN B told LN A that staff must be seated when feeding residents. LN B said sitting with residents, making eye contact and engaging with residents during assistance with feeding were "a matter of dignity." <Resident #30> Resident #30 was admitted to the facility on [redacted]14 for rehabilitation services. On 3/16/14 at 4:47 p.m., Resident #30 told the surveyor about an incident she witnessed involving Residents #20 and #36.	F 241		

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F 241	Continued From page 10 Resident #30 said one morning shortly before breakfast in the Oceanside dining room she saw Nursing Assistant F "refuse" to give coffee to Residents #20 and #36 when they asked for it. Resident #30 said NA F told the residents she would not give them coffee because they already had some and other residents had not yet had a first cup. Resident #30 said NA F's tone sounded "angry" and it made Resident #30 feel "uncomfortable." Resident #30 said it appeared to her that the incident made Residents #20 and #36 upset. Resident #30 said she could not recall when the incident occurred. On 3/17/14 at 5:36 p.m., the Director Nursing Services said she had not heard about any complaints or incidents involving residents not getting coffee when they ask for it and said she would initiate an investigation. <Resident #20> Resident #20 was readmitted to the facility on [redacted]13 with diagnoses to include chronic obstructive pulmonary disease. The MDS, dated 12/25/13, indicated Resident #20 was cognitively intact, non-ambulatory and mobilized independently with use of a wheelchair. On 3/19/14 at 1:27 p.m., Resident #20 said that approximately one month ago he and Resident #36 were in the Oceanside dining room before breakfast. Resident #20 said that on that morning he had a coffee cup which he had used earlier to make instant coffee from his personal supply which he kept in his room. Resident #20 opened	F 241		

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F 241	Continued From page 11 his dresser drawer to show the surveyor a jar of instant coffee. Resident #20 said that on the morning of the incident, he brought the coffee cup he used to make instant coffee with him to the dining room. Resident #20 said when he and Resident #36 asked NA F for a cup of fresh coffee, NA F told them no, saying they had already had some. Resident #20 said when he explained to NA F that he had only had his own instant coffee, NA F did not believe the resident. Resident #20 said NA F was "rude ...condescending" and "adamant that she was not going to give us any coffee." Resident #20 said the incident made him feel "mad" and "upset." Resident #20 said it was not the only occasion when NA F refused to give him coffee before breakfast and said NA F "acts like it's coming out of her own pocket." Resident #20 said he stopped asking for coffee in the Oceanside dining room, where he eats his meals, and instead started going to the Lakeside dining room after breakfast because staff in that dining room never refused to give him coffee or made him feel bad for asking. <Resident #36> Resident #36 was readmitted to the facility on [redacted]14 with multiple medical diagnoses following an acute hospitalization. The MDS, dated 3/7/14, indicated Resident #36 was cognitively intact and mobilized independently with use of a wheelchair. On 3/19/14 at 3:33 p.m., Resident #36 said there was a recent incident in the dining room before	F 241		

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F 241	Continued From page 12 breakfast in which NA F refused to give Resident #20 and #36 coffee, and told the residents they already had some and had to wait until all other residents had coffee before they could have another cup. Resident #36 said she did already have one cup but Resident #20 only had his instant coffee. Resident #36 said Resident #20 told NA F he only had instant coffee but NA F would not listen and acted as if she thought Resident #20 was lying. Resident #36 said it happened more than once and said, "We can go to the other end if we want. They always help us." Resident #36 said, "I felt like she was talking to us like we were children. It was rude. She argued with him and kept it up. She could have just given him a cup of coffee." The facility failed to promote care for residents in a manner that maintains or enhances each resident's dignity and respect when staff fed Resident #32 her dinner in a hurried manner while standing over the resident and without interacting with the resident, and when staff spoke to residents in a manner they described as rude and condescending, telling Residents #20 and #36 they could not have coffee while they waited for breakfast in the dining room. These failures placed residents at risk for diminished self-esteem and diminished quality of life.	F 241		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility	F 244		

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F 244	Continued From page 13 must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to respond to a complaint raised at a Resident Council meeting when two current sampled residents (#s 20 & 36) reported they were unable to get coffee in the dining room while they were waiting for breakfast. This failure placed residents at risk for not having their grievances addressed. Findings include: Refer to F241 for failure to promote care for residents in a manner that maintains or enhances each resident's dignity when Nursing Assistant (NA) F spoke in a manner residents described as "rude" and "condescending" when NA F told Residents #20 and #36 they could not have coffee while they waited for breakfast in the Oceanside dining room. The residents stated that on multiple occasions NA F refused to give them coffee, and told the residents they already had coffee so they had to wait until other residents had coffee. Resident #20 said he told NA F he did not already have coffee from the facility supply, only a cup made from his own supply of instant coffee, but NA F did not believe him. Resident Council minutes reflected that	F 244	Grievance report will be completed for residents #20 and #36. Staff will be re-educated on grievance process and customer service. Administrator and or her designee will attend resident council meetings as invited to discuss grievances and concerns that they may have. The Grievance log will be brought to stand up meetings Monday through Friday for review. Grievance process will be audited monthly by the Administrator or designee. Any findings will be reviewed in Quality Assurance Team Meeting until substantial compliance is met and maintained.	

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F 244	Continued From page 14 Residents #20 and #36 were regular attendees at council meetings. Availability of coffee was an ongoing issue discussed at meetings between 9/2013 and 2/2014. On 10/3/13, minutes documented "Discussion of old business: Coffee getting better, served before meal." On 11/6/13, minutes documented "Discussion of old business: Coffee still slow to get at meal time." On 12/2013, minutes documented "Discussion of old business: Coffee" and indicated residents were told coffee was available any time, they just needed to ask for it. On 1/2/14, minutes indicated residents were being served coffee any time. On 2/5/14, minutes did not mention coffee. Review of Concern/Comment [Grievance] Logs from October 2013 through March 2014 did not reveal any documented issues related to coffee. On 03/17/14 at 5:36 p.m., the Director Nursing Services said she had not heard about any complaints or incidents involving residents not getting coffee when they asked for it and said she would initiate an investigation. On 03/19/14 at 12:59 p.m., Resident #44 said concerns about availability of coffee had been raised at multiple Resident Council meetings. Resident #44 said that Residents #20 and #36 had specifically talked about not being able to get coffee at breakfast time in the Oceanside dining room. On 3/19/14 at 1:27 p.m., Resident #20 said that at a recent Resident Council meeting, he and Resident #36 were planning to talk about difficulty getting coffee in the morning and discuss the how	F 244		

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F 244	Continued From page 15 NA F talked to them when they asked for coffee. Resident #20 said that during the meeting, held in the Lakeside dining room, NA F was in the vicinity, so the residents were unable to speak freely. On 3/20/14 at 10:05 a.m., during an interview with the Activities Director (AD) and the Administrator in Training (AIT), the AD said it was her role to coordinate and attend Resident Council meetings. The AD said it was her responsibility to document resident concerns and grievances on the Resident Council Response Form and deliver to the Administrator (ADM) and appropriate department managers. The AD said grievances were addressed at daily "stand up" meetings with department managers. The AD said that at a recent Resident Council meeting, Residents #20 and #36 reported they could not get coffee in the dining room before breakfast. The AD said she advised the residents that they could get coffee anytime they want it. The AD said she did not forward the concern to the ADM or department managers. The AD and AIT were unable to locate records of any concerns or grievances forwarded to the ADM or department managers about residents reporting they cannot get coffee in the mornings before breakfast. The AIT said she did not recall the issue ever being discussed at the morning stand up meeting. The facility failed to respond to a complaint raised at a Resident Council meeting when Residents #20 and #36 reported they were unable to get coffee in the dining room while they were waiting for breakfast. This failure placed residents at risk	F 244		

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F 244	Continued From page 16 for not having their grievances addressed.	F 244		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide advanced notice of a roommate change for 2 of 20 (#58 & 30) current sampled residents reviewed for roommate changes. This failure placed residents at risk for difficulty adjusting to a new roommate and a potential diminished quality of life. Findings include: 1) Resident #58 was admitted to the facility on [redacted]/12 with diagnoses including [redacted] and dementia. The resident's Minimum Data Set (MDS), an assessment tool, indicated the resident was independent with activities of daily living, was moderately cognitively impaired and able to make needs known. On 03/16/14 at 4:50 p.m., Resident #58 stated he/she was not given notice prior to a new roommate moving into the room. 2) Resident #30 was admitted to the facility on [redacted]/14 with diagnosis of a [redacted]. The resident's MDS indicated the resident was	F 247	Residents # 58 and #30 will be informed of any roommate changes in a timely manner. Residents will be provided with timely notice of a roommate changes. Resident will be placed on alert for roommate change. Residents receiving a new roommate will be informed in a timely manner and placed on alert charting. Licensed Nursing Staff will be re-educated on timely notification of roommate changes and placing affected residents on alert. Social Services will review 24 hours reports for any room changes. Social Services will be re-educated on roommate changes and new admissions practices. New admissions and room changes will be audited for timely notification and correct documentation. Results of these audits will be reviewed in Quality Assurance Team Meetings until substantial compliance is met and maintained	

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F 247	Continued From page 17 cognitively intact and able to make needs known. On 03/17/14 at 10:18 a.m., Resident #30 stated he/she was not provided with advanced notice prior to receiving new roommates. Resident #30 stated he/she was told about new roommates as they were moving into the room. On 03/19/14 at 3:11 p.m. the Social Services Director (SSD) stated a resident may get a new roommate over the weekend but it may not be charted until the next week. The SSD provided a copy of the Room Changes Policy which stated: "7. Monitors the resident's acclimation to the new environment 72 hours after the move and then periodically, documenting monitoring and interventions. 8. Monitor the new room and roommates' acclimation, documenting it in the medical record 72 hours following the move." On 03/20/14 at 3:05 p.m. Licensed Nurse D stated residents are told when they are getting a new roommate and go on alert charting. On 03/20/14 at 5:17 p.m., the Administrator in Training reviewed the medical charts with the surveyor and stated there was no documentation that Resident #30 or Resident #58 had received advanced notice prior to receiving a new roommate. "We need to document that." Record review also failed to show documentation that a resident or the roommate had been monitored for 72 hours after the move, per the facility policy.	F 247		

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F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to maintain comfortable water temperatures between 100 and 120 degrees Fahrenheit (F) in 8 of 25 current sampled residents' rooms. This failure had the potential to impact residents' comfort and quality of life. Findings include: During observations and interviews on 3/17 and 3/18/14 with Resident #s 69, 14, 37, 23, 25, 57, 10 and 13, it was learned the water temperature in their rooms was too cold for comfort. 1) On 3/17/14 at 12:11 p.m., Resident #57 indicated the water temperature was warmer today but needed to let it run a long time. 2) On 3/17/14 at 3:20 p.m., Resident #14 stated the water was barely warm at the sink in her room. The water temperature felt cool and after two minutes, measured 80 degrees F. The water pressure fluctuated from strong flow and then reduced to a dribble. 3) On 3/17/14 at 3:24 p.m., Resident #13 said the water "was really cool but they don't want it too warm to burn us, that's what they say but it could be warmer I think." After five minutes, the water	F 253	The water temperature in resident rooms for residents #s 69, 14, 37, 23, 25, 57, 10, and 13 have been adjusted to be between the temperatures of 100 and 120 degrees. The water temperatures in resident areas will be maintained between 100 degrees and 120 degrees in order to maintain the residents comfort and quality of life. The Maintenance Director will check water temperatures in resident rooms and resident areas 3 times a week at different times of day to ensure the temperatures are between 100 degrees and 120 degrees. Maintenance Director will be responsible for adjusting the temperatures on the water tanks to maintain correct temperature range. Maintenance Director will inspect the faucets and shower heads for appropriate water flow and functioning. Any defects found will be replaced or repaired as indicated. A mixing valve will be ordered and installed to prevent temperature fluxuation. The Maintenance Director will turn in weekly Water Temperature Logs to the Administrator for review. The Water Temperature logs will be reviewed in Quality Assurance Team Meetings until substantial compliance is met and maintained.	

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F 253	Continued From page 19 temperature in this room measured 88 degrees F. 4) On 3/17/14 at 3:30 p.m., Resident #23 stated the water temperature in her room was "too cold." After two minutes, the water temperature measured 80 degrees F. 5) On 3/18/14 at 10:30 a.m., Resident #69 stated the water was too cool. The temperature at the sink measured 88 degrees F. 6) On 3/18/14 at 11:30 a.m., Resident #10's room water temperature felt cool. 7) On 3/18/14 at approximately 3:30 p.m., Nursing Assistants (NA) H & I entered Resident #37 and #25's room to provide care. They stated when they enter a resident's room, they turn on the water and let it run to try to get warm water which could take up to seven minutes. After three minutes, the temperature measured 88 degrees. During tour with the Maintenance Director (MD) on 3/21/14 at noon, inspection of the two hot water storage (HWS) tanks revealed temperature settings at 130. Tank water temperatures were not taken. Thermometers were calibrated with the MD and then water temperature was checked in Resident #37 and #25's room and measured between 88 and 90 degrees F. Temperature tracking logs provided by the MD for March 2014, indicated temperature ranges between 100-115. He stated he randomly checks temperatures in the early mornings. He said he had no complaints from residents or staff about the water temperatures. He was not aware of staff members' practice of letting the water run for long periods of time to try to get hot water.	F 253		

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F 253	Continued From page 20 Failure to ensure water was at a comfortable temperature created the potential to negatively impact residents' quality of life.	F 253		
F 258 SS=D	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined the facility failed to ensure comfortable sound levels, over which the facility had control, were maintained throughout the facility. This failure had the potential to impact residents' quality of life. Findings include: On 3/16/14 at 2:45 p.m., Resident #43's television was loud enough to interfere with conversations occurring in the hallway with staff members and heard while in the Lakeside dining room. Several televisions throughout the facility, including the Oceanside dining room TV, were loud. Review of Resident #43's record indicated he re-admitted to the facility on [redacted]/14 and his assessment indicated he had no problems with hearing or listening to the TV. During interview on 3/16/14 at 4:45 P.M.,	F 258	Resident #30 will be interviewed regularly for noise level issues. Resident #57s family will be interviewed for noise level issues. Noise levels will be discussed at Resident Council meetings and any issues will be addressed by the facility. Staff will be re-educated on noise levels. Ear plugs and head phones will be provided to residents that need them or request them. The management team will make facility rounds and monitor noise levels. Any findings will be reported in stand up meeting and addressed by the team. Results of these rounds will be reported in the Quality Assurance Team Meetings until substantial compliance is met and maintained.	

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F 258	Continued From page 21 Resident #30 stated the nursing assistants who care for her used loud voices and at times, there were three TV's going at once. During interview on 3/17/14 at approximately 10:00 a.m., Resident #57's family member stated the loudness was especially bad during lunch. The failure to ensure appropriate sound levels throughout the facility created the potential to negatively impact residents' quality of life.	F 258		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions;	F 272	Residents #58 and #57 have had teeth/dentures re-assessed by the Director of Nursing. Dental referral has been made for Resident #58. Resident #57s daughter declined dental services for her mother. The residents care plans have been updated to reflect dental status and ADL assistance needed and the MDS will be correctly completed to reflect the correct status.	

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F 272	Continued From page 22 Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based observation, interview and record review, it was determined the facility failed to comprehensively assess 2 of 25 current sampled residents (#57 and # 58) for dental care and services. This failure prevented the facility from obtaining necessary information to develop a care plan and to provide the appropriate care and services for each resident. Findings include: <Resident #58> Resident #58 was admitted on [redacted]12 with diagnoses including dementia, hypertension, chronic kidney disorder, anemia and difficulty walking. The resident's Minimal Data Set (MDS), an assessment tool, dated 03/01/14, indicated the resident had no dental problems, no broken or	F 272	The Director of Nursing and the Resident Care Managers will review resident assessments for accuracy and update care plans and MDS as indicated Residents dental needs will be assessed upon admission. . The dental status of residents will be reviewed quarterly to ensure accuracy and care plans will be updated as indicated. The Resident Care Managers be re-educated on assessments. Completed MDSs will be brought to the IDT meetings for review and any discrepancies will be resolved as appropriate to reflect resident status . Results of these reviews will be brought to the Quality Assurance Team meetings to for three or until substantial compliance is met and maintained.	

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F 272	Continued From page 23 loosely fitting full dentures which included no chipped, cracked, uncleanable, or loose dentures. On 03/17/14 at 2:43 p.m., Resident #58 was observed to have dirty dentures, dark grayish stains completely covering the dentures, with some of the molars broken to the point of just having metal and no porcelain left. The [redacted] was missing completely from the upper denture. The rest of the teeth had multiple cracks, chips and stains. The bottom denture appeared to be loose and not fitting securely. On 03/20/14 at 4:06 p.m., when asked how s/he assesses residents' teeth for the MDS, Licensed Nurse B stated, "I look at their teeth." When shown Resident #58's MDS dental assessment, LN B stated, "That's what I would have done, examine the resident's teeth and saw no broken teeth and no mouth pain." At 4:07 p.m., LN B remembered, "[Resident #58] doesn't like us looking in his mouth, he doesn't like it." Licensed Nurse (LN) B stated that s/he would have asked Resident #58 questions in order to complete MDS dental assessment if s/he was unable to perform a direct observation of his mouth." On multiple occasions Resident #58 was willing to show his dentures to several surveyors and staff members. (On 03/17/14 at 2:43 p.m., 03/20/14 at 3:30 p.m., 4:00 p.m., 5:18 p.m., 5:48 p.m., and 5:55 p.m.) When asked if Resident #58 would be willing to show his dentures to the Social Services Director and LN B, Resident #58 stated, "Sure, no problem." At 5:58 p.m., after seeing Resident #58's	F 272		

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F 272	Continued From page 24 dentures, LN B stated, "I think that I coded it incorrect, I would have marked loose broken loosely fitting." LN B stated that if the MDS had been properly coded, the new assessment information would have triggered a referral to social services to set up an appointment with the denturist. Resident #58 had been in the facility for approximately [redacted] months, with MDS quarterly assessments done every three months, and was not identified to have any dental issues. <Resident #57> Resident #57 was admitted on [redacted]/12 with diagnoses including arthritis and dementia. The resident's MDS, dated 02/13/14, indicated the resident was unable to a complete cognitive assessment and experienced periods of delirium, and required personal assist of one with all activities of daily living including bed mobility. The MDS assessment indicated no dental problems were identified. On 03/17/14 at 9:53 a.m., during an interview, Resident #57's daughter stated, "That is one of my main concerns; my mother's bottom denture doesn't fit very well." On 03/21/14 at 3:15 p.m., Nursing Assistant (NA) B stated that s/he believed that Resident #57's bottom denture was uncomfortable. When asked how s/he determined this, NA B stated, "She [Resident #57] usually wants me to take it out first" and indicated that Resident #57 was very willing to have bottom denture removed, didn't refuse, and was routinely combative and rejected	F 272		

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F 272	Continued From page 25 care.	F 272		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based observation, interview and record review, it was determined the facility failed to provide the necessary care and services relative to personal hygiene/grooming for 1 of 25 currently sampled resident (# 58) reviewed for activities of daily living. This failure place the resident at risk of poor oral hygiene. Findings include: Resident #58 was admitted on [redacted]/12 with diagnoses including dementia, hypertension, chronic kidney disorder, anemia and difficulty walking. An initial mouth assessment indicated the resident's mouth was pink, no sores and had upper and lower dentures. The resident's Minimum Data Set (MDS), an assessment tool, dated 03/01/14, indicated the resident had moderate cognitive impairment including some short and long term memory loss	F 312	Resident #58 has been re-assessed and the appropriate referrals have been made. The residents care plan and MDS have updated to reflect his correct dental status and ADL needs. Residents currently in the facility will be reviewed to ensure their care plans and MDS accurately reflects their dental needs and care to be received. The Nursing Staff will receive re-education on proper oral care and reporting dental issues, reporting any changes in care needs to the Director of Nursing. The Director of Nursing or her designee will randomly inspect resident oral care for compliance. Results of these will be inspections will be addressed at the Quality Assurance Team Meeting until compliance is met and maintained.	

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F 312	Continued From page 26 and often needed cueing to remember. Resident #58 required one person physical assist with personal hygiene. The MDS also indicated that the resident had no dental problems, no broken or loosely fitting full dentures which included no chipped, cracked, uncleanable, or loose dentures. The resident's care plan indicated the resident had dementia, had minimal desire for cleanliness, and required staff reminders. Resident will be assisted by staff in performing activities of daily living that cannot be met by the resident. Oral care would be done twice a day and as needed. The resident's Care Directive, a tool to guide the nursing assistant's care, dated 03/05/14, indicated the resident had his own teeth and required cues to perform oral care in the morning and at bedtime. On 03/17/14 at 2:43 p.m., Resident #58 was observed to have dirty dentures, dark grayish stains completely covering the dentures, with some of the molars broken to the point of just having metal and no porcelain left. The right front middle incisor was missing completely from the upper denture. The rest of the teeth had multiple cracks, chips and stains. The bottom denture appeared to be loose and not fitting securely. At 4:00 p.m., when asked to explain the resident's Care Directive for oral care, Nursing Assistant (NA) B stated, "He [Resident #58] has his own teeth, is independent but requires cueing when brushing his teeth." NA B stated that s/he had assisted Resident #58 with mouth care in the past and NA B had brushed his teeth like this, and motioned as with a tooth brush in her mouth, indicating s/he had brushed his teeth with a tooth	F 312		

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F 312	Continued From page 27 brush in his mouth. At 4:20 p.m., when asked how often the staff assisted him to brush his teeth, Resident #58 stated, "Never! They never help me brush my teeth." The tooth brush in the bedside dresser had very dry tooth paste on it and it became dust when verified to see if the tooth brush was wet. At 5:41 p.m., during observation of oral care for Resident #58, NA B entered the bathroom with the resident and brought his tooth brush, tooth paste and kidney basin. NA B put tooth paste on the tooth brush and handed it to the resident who was standing in front of sink. Resident #58 proceeded to remove top dentures which had old crusty light beige substance on top surface, and started brushing the denture. At 5:43 p.m., NA B was informed that Resident #58 had top and bottom dentures, NA B stated, "Oh! [Shocked] They [staff who filled out Care Directive] should have written that down." NA B stated that he/she would notify the nurse if he/she had any concerns with a resident's broken, chipped, or loose dentures. At 5:48 p.m., Licensed Nurse (LN) A stated, "I do check to see if his [Resident #58's] teeth are brushed in the evening, he has his own teeth. He does have a major problem with the right front tooth [pointing to the right front top incisor]." LN A stated s/he did not notify Resident Care Manager of his/her concerns with Resident #58's problem with the right front tooth. In addition, LN A had not received any concerns from nursing assistants regarding any broken or damaged dentures for Resident #58.	F 312		

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F 312	Continued From page 28 Resident #58 had been in the facility for approximately [redacted] months, with MDS quarterly assessments done every three months, and was not identified to have any dental issues. Care Plan and Care Directive interventions were not evaluated for effectiveness or revised to improve outcome. Additionally, direct care staff was not aware that Resident #58 had dentures and did not inform their supervisors of any identified dental concerns for Resident #58.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure management of indwelling catheters per recognized standards of practice for 1 of 4 current sampled residents (#69) reviewed for catheter care. This failure placed residents at risk for infections and related complications.	F 315	Resident #69's care plan and care directive have been updated to include interventions for perineal care and catheter care. Current Residents will be reviewed for accurate care plans and care directives for perineal care and or catherter care. Nursing staff will be re-educated on perineal care and catherter care standards of practice and policies. The Director of Nursing or her her designee will conduct random demonstration on perineal care and catherter care by Nursing Assistants. Finding from these demonstrations will be brought to the Quality Assurance Team meetings for review for three months or until substantial compliance is met and maintained.	

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F 315	Continued From page 29 Findings include: Resident #69 was admitted on [redacted]/14 with diagnoses including [redacted] diabetes, [redacted] difficulty walking, chronic liver disorder, acute respiratory failure, history of falls and urinary tract infections. The resident's Minimum Data Set, an assessment tool, dated 12/11/13 indicated the resident was cognitively intact and required extensive assistance for elimination and personal hygiene. The resident's care plan indicated resident had an indwelling catheter and did not include interventions for perineal care or catheter care. The resident's Care Directive, a guide to direct the nursing assitant's care, dated 03/12/14, indicated the resident was incontinent, and did not indicate the use of an indwelling catheter nor any indication to perform catheter or perineal care. The facility policy entitled "Urinary Catheters" indicated "Hand hygiene must be done immediately before and after manipulating the catheter ...Clean around the catheter daily with soap and water." On 03/20/14 at 2:37 p.m., during observation of perineal care and catheter care, Nursing Assistant A (NA) cleansed down inner thighs and then without re-gloving or performing hand hygiene continued to cleanse the catheter. The catheter had dried medium brownish yellow crusty pieces on it, NA A attempted to remove crusty pieces by rubbing the catheter with a back	F 315		

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F 315	Continued From page 30 and forth movement, descending the catheter from the meatus downward and then returning to the meatus several times with the same side of the moistened towelette. On 03/21/14 at 2:58 p.m., when asked how often he received perineal and catheter care, Resident #69 stated that he did not receive perineal care and catheter care every day. "I know it is not every day and for that I am sure." At 3:00 p.m., when asked how often s/he performed catheter care, NA D stated every shift. When shown Resident #69's Care Directive and asked how s/he knew Resident #69 should receive perineal care and catheter care, NA D stated, "Right here," and pointed to the incontinent checked box, "that is how I would know he needed catheter care." NA D also indicated that s/he was a new employee and to check with NA C. At 3:08 p.m., when shown Resident #69's Care Directive and asked how s/he knew Resident #69 should receive perineal and catheter care, NA C stated, "It would be a little more difficult but we [nursing assistants] would have to go in [the room] and ask him [resident] and observe what would need to be taken care of."	F 315		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323		

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F 323	Continued From page 31 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure residents' environments were free of accident hazards for Resident #14 and that specific chemical cleansing cloths were not located within reach of residents. These failures placed residents at risk of harm from a cluttered environment and lack of supervision from accidental use of the wrong cleansing products. Findings include: 1) On 3/16/2014 at 4:30 P.M., Resident #14 was observed exiting the Oceanside dining room (DR). There were four pieces of resident care equipment stored near the dining room (DR) and the room of Resident #14. The resident stated she keeps running into things in the hallway and at that time hooked her wheelchair on the mechanical (Hoyer) lift that was left just outside the DR door. When the resident entered her room, she caught her leg on one of the three crank levers at the foot of the bed. She stated this happens all the time. When asked if they could place the lever under the bed, Nursing Assistants (NA) H & J could not do so. The Maintenance Director (MD) was available and provided the NA's with an inservice on how to store the handle under the bed and out of the way to prevent the resident from running into it. The resident was observed	F 323	Hoyer lift has been removed from the dining room area The resident's lever on the bed will be stored under her bed to prevent her from running into it. The hall ways will be kept clear of clutter and equipment for ease of passage by keeping any needed equipment on one side of hallway. Disinfecting/germicidal wipes will be stored in a manner that is not accessible to residents or visitors. Staff will be re-educated on proper storage of equipment and cleaning supplies as well as keeping hallways clear of hazards for residents, and storage of bed levers for resident safety. The Director of Nursing, Director of Maintenance and the Administrator will make rounds to inspect the facility to ensure clear hallways, proper storage of bed levers and of disinfecting/germicidal wipes as well as any other potential hazards. The safety committee will review in monthly meetings for three months. Finding of these rounds will be presented to the Quality Assurance Team until substantial compliance is met and maintained. Resident #46 will be assessed to rule out side effects of medication.	

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F 323	Continued From page 32 expressing her appreciation to the staff. The resident indicated this had been a long-standing problem for her when she needed to get to her bed. 2) On 3/19/14 at 12:45 pm., three containers of cleaning wipes were observed on a medication/treatment cart in the hallway next to the Oceanside dining room and were accessible to staff, residents and the public. The first container, ProCure Hand Sanitizing wipes could be used on skin. Review of product safety information for the second and third containers indicated they were disinfectant/germicidal wipes intended for hard surface cleaning only and not to be used with surfaces that may come into contact with skin, food or to be used for personal cleansing. When using the germicidal products, protective clothing/eyewear were required for prolonged exposure. Failure to keep the environment clear of hazards and to keep disinfectant/germicidal wipes in an appropriate area created the potential for staff, visitors and residents to incur accidents by accessing a cloth not designed for contact for with skin.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of	F 329		

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F 329	Continued From page 33 adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide adequate monitoring of medications for 2 of 5 current sampled residents (#46 & 36) reviewed for unnecessary medications. This failure placed residents at risk of experiencing side effects of medications and inadequate or delayed treatment. Findings include 1) Resident #46 was admitted to the facility on [redacted]/14 with diagnoses including [redacted] and [redacted] According to the resident's Minimum Data Set (MDS), an assessment tool, the resident was cognitively intact and required extensive assistance with activities of daily living (ADLs).	F 329	Resident #36 physician will be notified of blood glucose results. Residents' medication administration records will be reviewed and updated for monthly orthostatic blood pressure. System will be updated for orthostatic blood pressure to be taken after fall. Licensed Nurses will be re-educated on physician notifications and documentations. The Director of Nursing or her designee will audit diabetic records twice a week and correct any notification deficiency at that time. Fall incident reports will be reviewed in stand up meetings Monday through Friday for completion. Findings from these reviews and audits will be reviewed in Quality assurance Team Meetings until compliance is met and maintained. The Director of Nursing will be responsible for correction and compliance.	

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F 329	Continued From page 34 The resident's Medication Administration Record (MAR) showed the resident was given Risperdal, an anti-psychotic medication on a daily basis. A side effect of this medication is postural hypotension, a form of low blood pressure that happens when you stand up from sitting or lying down and can make you feel dizzy or lightheaded. The facility policy stated residents receiving an [redacted] medication (such as [redacted] should be monitored for postural hypotension. On 03/20/14 at 6:18 p.m., the Director of Nursing Services (DNS) stated according to Resident #46's MAR, the resident was not being monitored for postural hypotension. Record review showed the resident fell on 01/28/14 and 02/04/14 while attempting get out of bed and self-ambulate. There was no evidence that the resident's postural blood pressures (blood pressures taken while laying, sitting, and standing) were taken after the fall or during routine monitoring. 2) Resident #36 was readmitted to the facility on [redacted]/14 with multiple diagnoses including diabetes. According to the resident's MDS, the resident was cognitively intact. Review of resident #36's MAR showed the resident's blood glucose level was measured at 410 on 01/26/14, 403 on 01/28/1, 49 on 02/10/14, 483 on 02/21/14, 420 on 02/22/14 and 459 on 02/28/14, all of which are outside of established parameters of <60 or >400. On 03/20/14 at 2:55 p.m. Licensed Nurse (LN) D	F 329		

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F 329	Continued From page 35 verified abnormal blood glucose levels had been documented on Resident #36's MAR in January and February and confirmed there was no documentation in the chart or on the back of the MAR to show the physician had been called. LN D stated, "There is no documentation that anyone called the doctor on those dates. Someone should have called the Doctor." At 5:20 p.m., the DNS stated she was not able to find documentation that the physician had been notified of Resident #36's abnormal blood glucose levels and confirmed the physician should have been notified.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to store, prepare and serve food in a sanitary environment and failed to serve food at the proper temperatures. This failure placed residents at risk of consuming contaminated food	F 371		

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F 371	Continued From page 36 and acquiring food borne illness. Findings include: On 03/19/14 at 12:10 p.m., a bag of noodles with a 3 inch by 3 inch hole was observed on a shelf in the food storage area. At 12:20 p.m., Kitchen Staff (KS) A was asked to check food temperatures at the steam table. KS A was observed setting the thermometer on the top of the steam table and on the cutting board between each temperature measurement. KS A was observed not thoroughly cleaning the thermometer between measurements and after placing the thermometer on unclean surfaces. At 12:26 p.m., while testing the temperature of the gravy, KS A dropped the thermometer inside the gravy and picked it out with her fingers. At 12:50 p.m., KS A stated, "I was doing good until I dropped the thermometer in the gravy." At 12:55 p.m., the Dietary Services Manager (DSM) was informed of the infection control concerns during the temperature tests conducted by KS A. The DSM acknowledged improper handling of the thermometer and stated, "I think she was nervous." On 03/20/14 at 12:01 p.m., the bag of noodles observed on 03/19/14 was observed again with the same hole in the bag, creating potential exposure to pests. At 12:02 p.m., DSM acknowledged the hole in the bag and stated they normally tie the end of the bag or tape the bag closed.	F 371	The kitchen will be audited for proper storage. The Dietary staff will be re-educated in the following areas; proper food storage, rotation of new/older stock, appropriate temperatures for food service, the use of the thermometer, cleaning of the thermometer for temperature taking, The Nursing staff will be re-education on proper handling utensils and hand washing and to obtain permission before applying clothing protector. The management staff will monitor meal service and report issues for immediately correction The results of monitoring will be reviewed in Quality assurance Team Meeting until compliance is met and maintained.	

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F 371	Continued From page 37 At 12:03 p.m., KS B was observed unloading a food order and adding a bag of dry rice to a container that had approximately four (4) inches of rice left in the container from a previous order. KS B did not clean out the container prior to adding the new rice or place the oldest rice on top. KS B stated no other containers were available to put the rice in. At 12:07 p.m., a test tray was placed on the cart that was being used to deliver meals to residents in their rooms. At 12:08 p.m. the DSM was observed asking Nursing Aide (NA) E to get the food out as quickly as possible. At 12:27 p.m. the last resident meal was delivered and NA E placed the test tray at the nurse's station. The Registered Dietician (RD) was asked to conduct the temperature testing using the facility's thermometer. The regular meal was tested first and the temperature of the chicken measured at 116 degrees. The RD stated, "That can't be right." The milk was measured at 48 degrees and the sour cream was measured at 82 degrees. The RD stated the sour cream was at 82 degrees because it had been placed next to hot food. The surveyor taste tested the sour cream, which was warm. The RD acknowledged that was how it was served to the residents. The zucchini was 108 degrees. The RD then asked a staff member to get another thermometer from the kitchen. The second thermometer was used to test the pureed food from a separate tray. The temperatures were measured immediately after the lid was removed. The pureed zucchini was 115 degrees and the pureed chicken was 118. The surveyor taste tested the food items and found them to be	F 371		

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AMERICANA HEALTH & REHAB CTR	917 7TH AVENUE LONGVIEW, WA 98632

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 38 luke warm. The DSM was present during the temperature testing and stated, "I saw all of the temperatures and they are all in the danger zone." <Food Service> On 03/16/14 at 6:18 p.m., Licensed Nurse (LN) A touched drinking surface of glass when serving a drink to Resident # 15 in Lakeside dining room. At 6:21 p.m., LN A placed a clothes protector on for Resident #41 without first asking permission in Lakeside dining room. At 12:08 p.m., Nursing Assistand (NA) A touched the drinking surface of a glass when serving a drink to Resident #53 in Lakeside dining room. On 03/19/14 at 12:22 p.m., NA A touched the drinking surface of a glass when pouring water into glass and then putting plastic lids on. At 12:24 p.m., NA A used hand sanitizer to perform hygiene, and not soap and water, while serving lunch to the residents in the Ocean Side dining room.	F 371		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency	F 412		

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F 412	Continued From page 39 dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to provide necessary dental services for residents with dental problems for 3 of 4 current sampled residents (#38, 57 & 58) reviewed for dental services. This failure placed residents at risk for ongoing dental problems without treatment. Findings include: <Resident #38> Resident #38 was admitted to the facility on [redacted]13 with diagnoses to include muscle weakness, dementia and a [redacted] The Nutrition Evaluation Form, dated 5/14/13, stated Resident #38 had missing [redacted] teeth. The Minimum Data Set (MDS), an assessment tool, dated 10/31/14, indicated Resident #38 had "obvious or likely cavity or broken natural teeth." The MDS further indicated Resident #38 was alert and able to express herself and could comprehend most conversation. The resident required extensive assistance with activities of daily living including locomotion on the unit, dressing and hygiene.	F 412	Residents #58 #57 and #38 have been assessed by the Director of Nursing for dental needs Dental referral has been made for residents #58 and #38. Resident #57s daughter was consulted and refused further dental care for her mother. The system put in place for Social Services to track residents dental needs, referrals and appointments. Nursing Management will be re-educated for dental needs and referrals. Outcomes of dental visits will be reviewed in Team Meetings to ensure appropriate follow up is completed. Audits will be completed by the Director of Nursing or her designee to ensure appropriate documentation of visits is in place and that residents dental needs are being addressed. Social Services will maintain a list of residents in need of dental visits and the dates of appointments as well as the results of appointments for these residents. This list will be reviewed in Team Meetings to ensure all disciplines are aware of the appointments and any follow up needed is completed. These logs will be reviewed in Quality Assurance Team Meetings until compliance is met and maintained.	

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F 412	Continued From page 40 Resident #38's Oral/Dental Care Plan, updated on 1/29/14, indicated the resident had "carious teeth." Interventions included "dental referral" as needed. On 3/16/14 at 3:59 p.m., Resident #38 was observed to be missing two natural [redacted] teeth. The resident said the teeth "came out a couple months ago." The remaining teeth adjacent to the empty spaces left by the missing teeth were observed to have areas of gray discoloration. On 3/20/14 at 11:14 a.m., the Director of Nursing Services (DNS) and the surveyor reviewed Resident #38's record and were unable to locate documentation to show that the resident had been referred for dental services to address the missing teeth and discolored adjacent teeth. The DNS said an oral/dental assessment should be conducted by nursing staff on admission and ongoing assessments should be made by unit nurse managers. The DNS said when oral/dental issues were identified they should be forwarded to Social Services for follow up with dental services. On 3/20/14 at 2:13 p.m., the Administrator in Training (AIT) (formerly the Social Services Director) stated that when nursing staff forwarded concerns to Social Services about residents with oral/dental issues, those residents were placed on a list of residents to be seen at the dental clinic which had an agreement with the facility to see facility residents, including those who were on Medicaid.	F 412		

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F 412	Continued From page 41 The AIT further stated Social Services was not advised regarding Resident #38's missing natural teeth. The AIT said if the information had been forwarded to Social Services, the AIT would have placed Resident #38 on the list of residents to be seen at the dental clinic. On 3/20/14 at 2:39 p.m., when asked if she would agree to see a dentist about her missing teeth if someone arranged an appointment for her, Resident #38 said, "Yes, I might." <Resident #58> Resident #58 was admitted on [redacted]12 with diagnoses including dementia, hypertension, chronic kidney disorder, anemia and difficulty walking. The resident's MDS, dated 03/01/14, indicated the resident had moderate cognitive impairment including some short and long term memory loss and often needed cueing to remember. Resident #58 required one person physical assist with personal hygiene. The MDS also indicated that the resident had no dental problems, no broken or loosely fitting full dentures which included no chipped, cracked, uncleanable, or loose dentures. On 03/17/14 at 2:43 p.m., Resident #58 was observed to have dirty dentures, dark grayish stains completely covering the dentures, with some of the molars broken to the point of just having metal and no porcelain left. The right front middle incisor was missing completely from the upper denture. The rest of the teeth had multiple cracks, chips and stains. The bottom denture appeared to be loose and not fitting securely. On 03/20/14 at 5:18 p.m., Social Services	F 412		

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F 412	Continued From page 42 Director (SSD) stated the facility has a denturist who comes directly to the facility to see residents experiencing denture issues and that s/he schedules appointments for the residents. The SSD stated s/he does not make any direct observation of the condition of the resident's dentures, but relies on notification from the nursing staff to place a resident on the list to see denturist if needed. At 5:44 p.m., Resident #58 stated he would like new dentures but he does not have a job. At 5:56 p.m., as Resident #58 showed SSD his dentures, the SSD stated, "I will make an appointment [to see the denturist]." SSD stated the denturist is coming this Monday, and assured Resident #58 would be on the schedule. <Resident #57> Resident #57 was admitted on [redacted]/12 with diagnoses including arthritis and dementia. The resident's MDS, dated 02/13/14, indicated the resident was unable to a cognitive assessment and experienced periods of delirium, was a one person assist with all activities of daily living including bed mobility. The MDS assessment indicated no dental problems were identified. On 03/17/14 at 9:53 a.m., during an interview, Resident #57's daughter stated, "That is one of my main concerns; my mother's bottom denture doesn't fit very well." On 03/20/14 at 7:12 p.m., the SSD stated that when Resident #57 saw the denturist, the	F 412		

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F 412	Continued From page 43 resident tried to bite the denturist. The SSD stated the appointment with denturist was a long time ago, about 5 months ago, and indicated there was no documentation or record of the denturist visit. No further follow up was initiated. There was no effort to investigate the cause of rejection of care including no attempt to remedy or ease the resident's combativeness.	F 412		
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the	F 431		

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F 431	Continued From page 44 Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to dispose of expired medications, and failed to ensure medications were stored under sanitary conditions for 4 of 6 medication/treatment carts and 2 of 4 medication storage rooms. This failure placed residents at risk of receiving expired medications and placed residents at risk of exposure to medications that were not sanitary. Findings include: On 03/19/14 at 10:20 a.m., the following was found during observation of the Lakeside medication room: the refrigerator had stains and debris on the shelves and surfaces, ice build-up in freezer, dust on most horizontal surfaces in the medication room including behind the refrigerator and the floor. Empty boxes on floor near garbage, no soap in soap dispensers, dried water marks and dust in the sink were observed. LN C confirmed findings and stated, "Yes, that is dirty dust behind the fridge and dust on floor. I see tape on the Formica. The sink is old." At 10:58 a.m., the following was found during observation of the Oceanside medication room: a heparin lock syringe 100 units/ml expired 2013,	F 431	Expired medications and supplies have been removed and properly destroyed. Ice buildup in freezer has been defrosted and cleaned. Pharmacy consultant will conduct an audit of medication carts, medication rooms and refrigerators for expired medications/supplies and storage. Daily audits of medication and treatment carts to be conducted by the Director of Nursing services and/or Resident Care Managers Maintenance Director will powerwash the medication and treatment carts quarterly. The night shift charge nurse will defrost and clean the medication room refrigerator and freezer every two weeks to maintain compliance. The Director of Nursing to provide a cleaning schedule of the Medication room twice a week. Random audit of refrigerator and Medication rooms to be conducted by Director of Nursing or her designee. Results of these audits will be reported in the Quality Assurance Team meetings until compliance is met and maintained.	

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F 431	Continued From page 45 Meropenem 1 gram vial expired 02/2014. LN C confirmed findings. On observation of darkened area on wall under sink, the Maintenance Supervisor (MS) stated, "Must have had a leak." The MS stated the darkened area looked more like old rust, pointing out that the drain pipe also had rust on it. At 11:24 a.m., the following was found during observation of the Oceanside Overflow cart: six swabs of Starswab II expired January 25, 2014. Dust was found on back rubber ledge at bottom of cart and top surface of the cart had a small amount of dust and debris. LN C confirmed the findings and stated, "Yes, it's a little dirty." At 11:40 a.m., the following was found during observation of the Lakeside Overflow cart: a Ventolin inhaler 90 micrograms that expired on 10/ 2013, drawers of the medication cart had dust and debris, the pill crusher had thick orangish dried up debris. LN C stated, "It [the medication cart] is dirty." LN C stated, in reference to the orangish debris on pill crusher, "It's pill dust."	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441		

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F 441	Continued From page 46 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure staff washed hands according to professional practice after direct resident contact and failed to clean residents' shared respiratory equipment as required to prevent the transmission of infection. These failures placed residents at risk of exposure to infections.	F 441	Resident #77 oxygen concentrator has been inspected, cleaned and placed away from any blockage with a dated full humidifier bottle. Oxygen concentrators used by residents will be inspected and cleaned on a weekly schedule per manufacturer's instructions, filters and tubing to be changed weekly and documented on MAR. Oxygen Concentrators will be free of obstructions of air flow. The Licensed Nursing staff will be re-educated on dating and replacing the humidifier bottles. Staff will be re-educated on proper hand hygiene including hand washing and sanitizers. The housekeeping staff will ensure that there is soap in the soap dispensers throughout the facility and that sinks are clean and free of debris. The housekeeping staff will be re-educated on timely refilling of soap dispensers, cleaning sink areas and sinks. The Director of Nursing or her designee will perform random audits of the MARS and oxygen concentrators for filter change, cleaning and humidifier bottles. The Director of Nursing or her designee will perform random audits of hand washing. The results of these audits will be reported to the Quality Assurance Team until compliance is met and maintained.	

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F 441	Continued From page 47 Findings include: <Respiratory Therapy Equipment > An Oxygen Concentrator (OC) is a device for delivering medical oxygen to patients who require respiratory assistance. By extracting the oxygen it delivers from the surrounding air and using multiple filtering processes, the concentrator delivers a flow of oxygen that will typically have a purity of up to 95%. The oxygen is usually delivered through a nasal cannula (two small plastic tubes, or prongs) placed in both nostrils (National Institute of Health, February 24, 2012). According to manufacturer's recommendations for routine cleaning/maintenance of the concentrators, exterior filters (located on the sides or back of the machine) are to be cleaned weekly by: 1) replacing with a new filter; 2) vacuuming or 3) washing in warm water with non-lotion liquid soap. The filter is rinsed with warm water and gently squeezed and patted dry with a clean towel. When the filter is completely dry, it is placed back on the machine. The exterior cabinet of the machine is not to be sprayed with chemicals but rather washed with a mild household cleaner and non-abrasive cloth or sponge. 1) On 3/20/14 at 2:00 p.m., observation of the equipment storage room revealed seven concentrators that were not clean. The Director of Nursing Services (DNS) and the Director of Housekeeping (DH) were asked about the service maintenance records and how the concentrators and filters were checked/cleaned. According to the facility's contract with an oxygen supplier, a service representative would be	F 441		

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F 441	Continued From page 48 provided for "weekly visits...for the purpose of delivering and maintaining oxygen equipment." Neither the DNS nor DH could provide documentation of recent maintenance records, filter change tracking logs or a policy and procedure for how the concentrators should be cleaned/maintained by facility staff members during, after and before use by residents. The DH stated his staff members cleaned the concentrators and his assistant demonstrated the cleaning process on one of the concentrators with the DH and DNS present. The process included: spraying the entire machine with QUAT (chemical disinfectant); removal of the filter on the right side (the left filter was missing) and sprayed with QUAT. She sprayed the filter openings with QUAT. The filter was rinsed in the sink, excess water squeezed out and, while still wet, the filter was placed back on the machine. When the DH's assistant was asked who taught her how to clean the concentrators, she said her previous manager. She said she had no other training nor had she seen any cleaning/maintenance policy/procedures. The DH said there was no policy or procedure for cleaning/maintenance and he had no documentation to show when the machines were last serviced or filters were cleaned. This practice was not in accordance with the manufacturer's recommendations for cleaning concentrators and had the potential to keep staff from identifying and analyzing the source of infections 2) On 3/20/14 at 9:30 A.M., during observation of	F 441		

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F 441	Continued From page 49 Resident #77"s oxygen concentrator/equipment, the machine was against the wall with a curtain hanging around it and a 10 x 10 inch piece of thin plastic covered the external air filter (manufacturer requirements: never block air openings, keep at least 3 inches from walls, draperies, furniture). The humidifier bottle was empty and not dated. <Handwashing> "Washing hands with soap and water is the best way to reduce the number of microbes on them in most situations. If soap and water are not available, use an alcohol-based hand sanitizer that contains at least 60% alcohol" (Center for Disease Control and Prevention, December 11, 2013). During medication observation at 10:00 a.m. on 3/17/14, Licensed Nurse (LN) E administered medications to Resident #25 who was sitting in the Oceanside dining room. The LN placed her fingers inside the medication cups to separate them prior to pouring medications in them. While administering the medications to the resident without gloves, she used tissues to wipe secretions from the resident's mouth several times. The LN readjusted the Resident's clothing and her chair placement and picked up all items on the table and discarded them. The LN returned to the medication cart and without washing her hands with soap and water, used a thin 4 x 6 inch towelette, pressing it in her hand a couple of times and not used as recommended by the manufacturer (Manufacturer recommended: "Wipe hands, fingers, interdigital [between fingers] areas and	F 441		

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F 441	Continued From page 50 wrists thoroughly with towelette. Be sure to utilize the entire wipe. Allow to dry"). She discarded the wipe and continued to administer medications to other residents. When asked where staff members could wash their hands, she said there was a sink that staff could use and pointed to a room (Utility and Eye wash) across the hall near the medication cart. Upon inspection of the area the LN identified for staff handwashing, the "Utility/Eye wash" room, it was observed to have a soiled double counter sink, a broken and empty soap dispenser, a contaminated large floor sink for bodily waste disposal, and several trash barrels. Three contaminated washbasins; a bedpan placed in one of the washbasins and a commode/toilet lid was on top of the bedpan in the right side of the sink. The eye wash faucet covers were hanging down near the contaminated items. The DH and Maintenance Director observed the room at 10:30 a.m. and neither had not known this room to be used as a handwashing sink for staff. Failure to keep care areas sanitary, ensure staff washed hands, and cleaned/maintained respiratory equipment/concentrators as required, placed residents at risk for infections.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465		

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AMERICANA HEALTH & REHAB CTR	917 7TH AVENUE LONGVIEW, WA 98632

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 51 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the outside courtyard was safe, functional and in good repair for use by residents, staff members and the public. This failure created the potential for injury and loss of enjoyment to those who visited the courtyard. Findings include: 1) On 3/19/14 at 3:00 p.m., inspection of the residents' courtyard revealed uneven and separated concrete. The gaps in the concrete measured approximately 4 inches in width in several places of the patio. 2) The wood planter surrounding a tree and designed for seating was not smooth and was splintered. There were no other seating options in the area. 3) On 3/16/14, the rain gutters overflowed to the courtyard where residents would sit to get out of bad weather. 4) There was no covered area to protect residents, family members or visitors from sun, rain or other adverse weather conditions. These failures placed all who visited this area at risk for injury and decreased comfort, enjoyment and quality of life. Refer to F 240.	F 465	Residents, staff and visitors will be provided with a safe and functional courtyard area for their enjoyment. Any gaps in the concrete will be leveled/filled as able by the Director of Maintenance. Any areas that are not able to be repaired will be marked or covered to ensure safety of anyone in the courtyard. Seating and covered space will be provided in the courtyard . All areas of the courtyard will be inspected and repaired as indicated. Smoking area will be moved to new location for resident comfort and the prevention of second hand smoke. The Maintenance Director will be responsible for inspecting and monitoring all areas of the court yard on a weekly basis Any identified needs or issues will be presented to the Quality Assurance Team for three months or until compliance is met.	