

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

PRINTED: 07/30/2013
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505311 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 07/16/2013 |
| NAME OF PROVIDER OR SUPPLIER SEATTLE MEDICAL POST ACUTE CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 555 16TH AVENUE SEATTLE, WA 98122 | | |
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| F 000 | <p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced (night) Quality Indicator Survey conducted at Seattle Medical Post Acute Care on 07/08/13, 07/09/13, 07/10/13, 07/11/13, 07/12/13, 07/15/13 and 07/16/13. The survey included data collection on 07/12/13 from 4:30 a.m. to 8:00 a.m. A sample of 27 residents was selected from a census of 87. The sample included 25 current residents, the records of two former and/or discharged residents, and nine supplemental residents.</p> <p>The survey was conducted by: [REDACTED], RN, MN [REDACTED], MSW [REDACTED], RN, MN</p> <p>The survey team is from: Department of Social and Health Services Aging and Adult Services Administration Residential Care Facilities Region 2, Unit F 20425 72nd Avenue South, Suite 400 Kent, Washington 98032-2388</p> <p>Telephone: (253) 234-6000 Fax: (253) 395-5070</p> <p><i>Mari Ferguson-Woelfel</i> Residential Care Services Date 7/30/13</p> | F 000 | <p>DISCLAIMER CLAUSE</p> <p>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.</p> <p>RECEIVED AUG 12 2013 DSHS/ADSA/RCS</p> | | |
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Rachael Garcia</i> | | | TITLE Executive Director | | (X6) DATE 8/8/13 |

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

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| F 242 SS=D | <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to allow two (#s 71 and 23) of three residents reviewed for choices, of the 12 residents who were interviewed in Stage 1, the right to make choices regarding important daily routines, including accommodating preferences for a tub bath and frequency of bathing. The facility's failure to have a tub bath in which residents could be bathed, and failure to provide the number of showers a week requested, placed residents at risk for a diminished quality of life and poor hygiene.</p> <p>Findings include:</p> <p>RESIDENT #23 According to the 02/27/13 Minimum Data Set assessment (MDS), Resident #23 indicated it was "very important" to choose between a tub bath, shower, bed bath or sponge bath. In an interview on 07/09/13 at 2:14 p.m., Resident #23 indicated he did not get to choose whether he took a shower, tub or bed bath. He stated, "I'd love to take a tub bath but I don't have a lot of strength. I can't stand... I'd love one (tub bath)". He further indicated staff had not offered him a choice</p> | F 242 | <p>F 242 SELF DETERMINATION-RIGHT TO MAKE CHOICES</p> <p><u>Plan of Correction</u></p> <ol style="list-style-type: none"> 1. Resident number 23 preferences have been reviewed and educated on facility order of a tub. 2. Facility will order a new tub that will be made available for residents who prefer to or request a bath. 3. Quality Assurance Committee will ensure compliance <p>Residents will be interviewed upon admission and quarterly to preferences. Any preference that cannot be met within facilities abilities will be forwarded to the Executive Director.</p> | 8/22/13 | |

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| F 242 | <p>Continued From page 2 between a shower and a tub bath and that he received only showers.</p> <p>In an interview on 07/12/13 at 9:45 a.m. Staff K, Shower Aid, stated each resident on the floor where she worked received a shower. She explained the "Tub Room" was used for storage. She stated there were "a few people I would love to soak in a tub, but I'm not able to."</p> <p>In an interview on 07/12/13 at 10:00 a.m., Staff L, Shower Aide, stated she did not have a key to the room labeled "Tub Room." She explained she did not know what was in the room as she only used the shower room. She stated she had never provided a tub bath.</p> <p>In an interview on 07/12/13 at 11:00 a.m., Staff J, Maintenance Director, stated he had been at the facility for five years. He stated while there were tubs on each of the facility's three floors, the "Tub Rooms" were used for storage. He explained the tubs had not been used since he had been at the facility. He explained, "Technically, water is still hooked up to them but they probably couldn't be used" due to the length of time they had been inactive.</p> <p>In an interview on 07/16/13 at 10:20 a.m., Staff M, Licensed Nurse, stated when staff conducted the "preference interview" with residents, they were told the facility cannot give a tub bath but the resident had a choice between a shower or a bed bath. She stated the facility did not "have the availability of a tub bath".</p> <p>In an interview on 07/16/13 at 11:40 a.m., Staff A, Administrator, stated while the facility did have a bathtub on each floor, they were not functional,</p> | F 242 | | |
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| F 242 | <p>Continued From page 3</p> <p>nor had they been used in several years. She stated she was not aware there were residents who would prefer a tub bath. She acknowledged residents were not offered or provided tub baths.</p> <p>RESIDENT #71 In an interview on 07/09/13 at 9:58 a.m., Resident #71 stated, "I don't think they have a bath here... I've not been asked (about a preference for a tub bath)". In addition, he stated he did not get to chose how many times a week he received a shower. He stated he received two showers a week but, "I would prefer at least three (showers) a week... I talked to somebody and they said they'd see what they could do but still haven't done anything."</p> <p>According to the [REDACTED] 13 admission MDS, Resident #71 indicated it was "very important" to chose between a tub bath, shower, bed bath or sponge bath.</p> <p>The June Shower/Bath Sheet indicated the resident received a shower twice a week. Failure to ensure a resident was provided with the opportunity to make choices about aspects of his/her life that they find significant and important placed them at risk to not feel valued and autonomous.</p> | F 242 | |
| F 248 SS=E | <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> | F 248 | |

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| F 248 | <p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to provide an ongoing program of activities for three (#s 17, 10 & 71) of three residents reviewed for activities of the 35 residents who were included in the Stage 1 sample, and one supplemental resident (#119). This failure did not promote the residents' mental and psychosocial well-being and placed them at risk for social isolation, boredom and a diminished quality of life.</p> <p>Findings include:</p> <p>RESIDENT #17 INDIVIDUALIZED ACTIVITIES On 07/09/13 at 9:06 a.m. Resident #17 was unable to respond to questions asked due to her medical condition. In an interview on 07/09/13 at 10:47 a.m., Resident #17's representative said "I have her TV set to go off at 11 p.m.. It will flip channels on its own, they keep unplugging it and I have to reset it."</p> <p>According to the 05/15/13 Activities care plan (CP), the resident's current interests were scary movies, TV, comedies, cartoons, music, and the Discovery Channel. On 07/09/13 at 9:08 a.m. a note was observed posted on the Television (TV) at the resident's bedside which said "Turn on TV daily Channel 15."</p> <p>During observations on 07/09/13 at 9:08 a.m., 10:32 a.m., 11:30 a.m. and 2:28 p.m., the TV was observed to be on CNN where a trial was being televised. Similarly the TV was observed to be on</p> | F 248 | <p>F 248 ACTIVITIES MEET INTEREST/NEEDS OF EACH RESIDENT</p> <p><u>Plan of Correction</u></p> <ol style="list-style-type: none"> 1. Resident # 17, 10, 71, and 119 activity interests and needs have been re-assessed, Care Plans have reviewed and updated. <p>Staff have been educated and informed of residents #17, 10, 71, 119, 76, 9, 48, 21, 94, 15 individuals interests/needs. (resident #28 has discharged from the facility)</p> <ol style="list-style-type: none"> 2. Resident Activity interests and needs have been reviewed and updated accordingly. <p>Facility "get up" schedule has been reviewed and updated as needed.</p> <ol style="list-style-type: none"> 3. Staff have been re-educated on following resident individual activity interests/needs of the residents. <p>Staff have been re-educated on the system of facility "Get Up" schedules.</p> <p>Executive Director, DNS or designee will review "get up" schedule daily with nursing and activity staff.</p> <p>Activity staff have been re-educated by the Executive Director on following resident individualized Care Plans</p> | 8/22/13 |

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| F 248 | <p>Continued From page 5</p> <p>the CNN televised trial on 07/11/13 at 11:00 a.m., 11:15 a.m. and 1:47 p.m.</p> <p>According to the facility Channel Listings, CNN is on Channel 14 and the Cartoon Network is on Channel 15. In an interview on 07/15/13 at 8:36 a.m. Staff U, Activity Director, when asked if CNN met Resident #17's planned preferences, Staff U replied, "No, that might not...".</p> <p>Further review of the 05/15/13 Annual Activity Evaluation indicated the resident had interest in the activity of "Being read to." The 05/15/13 Activities CP listed interventions including "Sensory Stimulation of reading aloud." According to documentation on the Activity Logs, staff last read aloud to Resident #17 on 04/29/13.</p> <p>GROUP ACTIVITIES</p> <p>In an interview on 07/09/13 at 10:50 a.m. when asked if staff encouraged Resident #17 to attend activities, Resident #17's representative said "No, they used to on Fridays she went to a sensory group. I would like her to go back to those things, they used to take her out of her room in her chair twice a week. I don't think they've been doing that for a long time."</p> <p>Review of the planned activity calendar revealed a Sensory Group scheduled on the second floor, at 4:00 p.m. daily Monday through Friday.</p> <p>According to the resident's 05/15/13 Activities CP, a goal was for Resident #17 to attend Sensory Stimulation small group program. The CP did not list interventions to meet the listed goal. Review of the 05/15/13 Activities of Daily Living (ADLs) CP listed the intervention to assist the resident "Out of bed (Tuesday, Thursday, Saturday) in</p> | F 248 | <p>and expectations of one to one resident visits.</p> <p>4. Executive Director and or designee will perform random audits to ensure that Residents individual interests/needs are being met and Care plan and "get up" schedule is being followed for 3 months.</p> <p>Quality Assurance Committee will ensure compliance</p> | 8/22/13 |
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F 248

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appropriate chair" and "Encourage out of room activities daily for socialization." The Daily Get up List identified Resident #17 as an Evening Shift get up on Tuesday, Thursday and Saturday. None of the approaches included a time to ensure the resident was available to attend the 4:00 p.m. Sensory Group.

Review of the 05/15/13 Annual Activity Evaluation indicated the resident preferred activities in small group, 1:1 and in own room. The activity evaluation and plan did not indicate the resident was attending group or a plan to encourage attendance.

According to documentation on the Activity Logs, Resident #17 last attended the Sensory Group on 05/06/13.

In an interview on 07/16/13 at 10:06 a.m. Staff F, 2nd floor RCM, said Resident #17 was gotten out of bed in the evening on Tuesday, Thursday and Saturday per her daughter's preference, some time after 3:00 p.m., normally 4:00 p.m. or 4:30 p.m.

In an interview on 07/15/13 at 8:36 a.m. Staff U said the nursing staff "used to get her up for sensory group" but "she hasn't yet this month". Failure to ensure Resident #17 was provided with activities, both individual and group, that she was assessed to enjoy placed her at risk for isolation and boredom.

TV NOT BASED ON PREFERENCE
When informed on 07/08/13 many of the dependent, cognitively impaired resident TVs on the 2nd floor were observed turned on to CNN live coverage of a court case, Staff U said, "I

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| F 248 | <p>Continued From page 7</p> <p>noticed that too but I didn't think nothing of that," "maybe they want to... a lot of it would depend on individual preferences".</p> <p>On 07/09/13 at 12:34 p.m. the following resident's TVs were turned on the CNN live coverage of a court case: Resident #76, #28, #9, #17, #48, #21, #94 and #15. On 07/15/13 at 8:36 a.m. while reviewing the above resident's CPs, Staff U said Resident #76's CP did not indicate channel preference for the TV and noted "he was kinda hard to get information as he's not English speaking and a lot of what we have to do is yes/no." Resident #28's CP indicated he liked TV, movies, sports, religious and action movies. Resident #9's CP indicated he preferred sports, football and TV. Resident #48's CP indicated she liked the shopping channel and game shows. Staff U commented, "I'm surprised, usually she's watching Family Feud and stuff in there." Resident #21's CP indicated her preference was TV and religion, but did not have more specific information regarding channel preferences. Regarding Resident #94, Staff U commented, "She's alert but she's (not English) speaking and has a little book with pictures so she can make her needs known". Resident #15's CP indicated a preference for sports TV, music, and movies. "I know that he's a big sports fan... We get (a local sports channel) so we could put it on that."</p> <p>In an interview on 07/15/13 at 8:36 a.m. Staff U said what is showing on a resident's TV "should match the CP if says cartoons should be that, if sports/news then that."</p> <p>RESIDENT #119 INDIVIDUALIZED ACTIVITIES On 07/08/13 at 10:52 a.m. Resident #119 was</p> | F 248 | <p>RECEIVED</p> <p>AUG 12 2013</p> <p>DSHS/ADSA/RCS</p> | |
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| F 248 | <p>Continued From page 8</p> <p>unable to respond to questions asked due to her medical condition. According to the 06/10/13 Admission MDS, staff assessed the resident's daily and activity preferences to include: Reading books, newspapers, or magazines, listening to music, bring around animals such as pets, keeping up with the news and spending time outdoors.</p> <p>The 06/12/13 Activities CP indicated the resident preferred activities of music, spiritual/religious, walking/wheeling, watching TV, and talking/conversing. Interventions included: provide resident with activity supplies for in room use as needed or requested; current interests for this resident are music, religion (catholic), reading aloud and sensory stimulation (flash cards, object touch, hand messaging).</p> <p>Review of the resident's record revealed a 06/25/13 Physician's Order directing the facility to "Please place TV or Radio in patients room to provide stimulation."</p> <p>On 07/08/13 at 10:57 a.m. Resident #119 was observed laying in bed with neither a radio or TV on. Similar findings were noted at 2:06 p.m. On 07/09/13 at 8:27 a.m. Resident #119 was observed in bed looking around the room. The TV on her side of the room was turned off. The TV on the roommate's side of the room was turned on, however the volume was not audible and the set was positioned so Resident #119 could not see the picture. The radio was turned off. Similar observations were noted on 07/10/13 from 12:15 p.m. until 2:19 p.m. in which the resident was observed in bed, without a TV or radio for stimulation.</p> | F 248 | | |
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| F 248 | <p>Continued From page 9</p> <p>In an interview on 07/15/13 at 8:36 a.m. Staff U said the radio "should be on" and indicated when Staff V (Activity Assistant) did 1:1's she turns on radios and TVs.</p> <p>On 07/11/13 at 10:52 a.m. Resident #119 was observed in bed and her roommate's TV was observed turned facing toward Resident #119 with the volume turned up. Resident #119 was in bed across the room. In an interview on 07/11/13 at 1:58 p.m. Staff V said that morning she was in the resident's room and turned the roommate's TV toward Resident #119 and said hello. Staff V said the entire visit lasted two to three minutes. The One-to-One Visit Log reflected the 07/11/13 visit as a "TV/Sensory" activity, in which the resident "Welcomed visit", "partial participation", "Smiled," and was "Alert".</p> <p>In an interview on 07/15/13 at 8:36 a.m. Staff U said "I think she's actually sharing a TV with (Resident #21), we're waiting for a wiring thing so they can wire the room for TV", "They put the TV where they could both see it." Upon entrance to the resident's room with Staff U on 07/15/13 at 9:43 a.m. Resident #21's TV was turned and not visible from Resident #119's bed. Staff U confirmed the TV was not visible. A small black clock radio was present in Resident #119's room, but was turned off.</p> <p>In an interview on 07/15/13 at 8:36 a.m. Staff U said the second floor activities, where Resident #119 resided, included the sensory cart (1:1) from 1:30 p.m. to 2:00 p.m.</p> <p>In an interview on 07/11/13 at 1:58 p.m. Staff V said on 07/08/13 the resident received the activity of "Social" which consisted of activity staff sitting</p> | F 248 | | <p>RECEIVED</p> <p>AUG 12 2013</p> <p>DSHS/ADSA/RCS</p> |
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| F 248 | <p>Continued From page 10</p> <p>down and talking to the resident for three minutes. The One-to-One Activity Log had the resident's response as "Welcomed Visit", "Smiled", "Eye contact" and "Alert." In an interview on 07/15/13 at 8:36 a.m. Staff U expected 1:1 activities with the residents to be "three minutes at a minimum", "at a maximum I wouldn't want them to go over 15 minutes, because if we did 20 minutes we wouldn't have enough time to do all of the 1:1's."</p> <p>On 07/09/13 at 8:27 a.m. Resident #119 was observed in bed looking around the room. According to the posted activity calendar Sensory Cart was scheduled for 1:30 p.m. daily. On 07/09/13 the resident was observed from 1:30 p.m. until 2:30 p.m. in her bed. No staff was observed to enter the room to provide sensory stimulation.</p> <p>Similar observations were noted on 07/10/13 from 12:15 p.m. until 2:19 p.m. in which the resident was observed in bed, without a TV or radio turned on for stimulation, and without staff provision of an activity. In an interview on 07/11/13 at 1:58 p.m. Review of the One to One visit log revealed staff documented "Music", which Staff V said on 07/10/13 she had provided a 1:1 visit of a gospel CD and hand message lasting a total of five to ten minutes.</p> <p>GROUP ACTIVITIES According to the [REDACTED]/13 Admission MDS, staff assessed the resident's daily and activity preferences to include doing things with groups of people, participating in favorite activities and spending time outdoors. According to the MDS, the resident was not transferred out of bed (other than to be bathed), did not leave the unit or get up</p> | F 248 | | |
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| F 248 | <p>Continued From page 11</p> <p>in a wheelchair during the seven day look back period prior to the MDS.</p> <p>The 06/12/13 Activities CP indicated the resident preferred activities in the setting of own room and day/activity areas. The listed goals included "Will attend at least one activities of choice per week", and "Res(ident) will follow non-verbal cueing & gestures as evidenced by active participation at group programs and/or 1:1 visits three times a week. Interventions included invite to activities daily, remind and encourage resident to attend activities that they particularly enjoy, assist resident to get up in time to attend activities of choice, current interests for this resident are sensory stimulation.</p> <p>In an interview on 07/15/13 at 8:36 a.m. Staff U said the second floor activities, where Resident #119 resided, included small group programs at 10:00 a.m. and 4:00 p.m.</p> <p>Resident #119 was not observed to get out of bed during the survey. On 07/15/13 at 9:55 a.m. Resident #119 was observed in bed and dressed in gown. On 07/15/123 at 10:10 a.m. Staff U was observed to bring Resident #18 into the activity room for Sensory group. No other residents or activity staff were observed in the room. On 07/15/13 at 10:27 a.m. there were no residents or activity staff observed in the activity room as scheduled.</p> <p>In an interview on 07/11/13 at 1:58 p.m. Staff V said, "I haven't seen her (Resident #119) get up." In an interview on 07/15/13 at 10:00 a.m. when asked if Resident #119 gets up, Staff O replied, "No she moves a lot, she's agitated." In an interview on 07/16/13 at 9:15 a.m. Staff C said "I</p> | F 248 | | | |

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| F 248 | <p>Continued From page 12</p> <p>personally have not seen her up. She moves around in the bed".</p> <p>In an interview on 07/15/13 at 8:36 a.m. Staff U said Resident #119 had not been up for any activities. When asked why, Staff U replied, "I don't know." When asked how the activity staff communicated to nursing staff which residents should be assisted up to attend group Staff U said, "I just talk to the RCM and he talks to the staff. We try and get them up", "Right now were having new people thing, sometimes they get them up after the group. Lately the group attendance is smaller than it has been (in the past). We bring residents up from both floors... Some of the folks are not medically ready for groups and the nursing staff may say leave them in bed."</p> <p>In an interview on 07/16/13 at 10:06 a.m. Staff F said the daily get up schedule was designed to show the CNAs which residents need to get up during the shift, based on resident/family preference, and color coded. Staff F said Resident #119 was supposed to get up during the day or with therapy and indicated there was no reason for her to not be up. Review of the Daily Get up List revealed Resident #119 was not listed, to which Staff F commented, "her name should be here and it should be marked as blue (day shift)".</p> <p>Failure to provide meaningful, ongoing activities, including sensory stimulation, placed Resident #119 at risk for social isolation and boredom.</p> <p>RESIDENT #10 On 07/08/13 at 11:00 a.m. Resident #10 was unable to respond to questions asked due to his</p> | F 248 | | |
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| F 248 | <p>Continued From page 13</p> <p>medical conditon. According to the 06/25/13 MDS, the facility assessed Resident #10 as requiring total assistance of two staff for bed mobility and transfers and indicated locomotion (out of bed) did not occur during the observation period.</p> <p>The 06/23/13 Activity CP listed the intervention of "Remind staff to get up in time to attend group program", which was scheduled daily Monday through Friday at 10 am and 4 pm.</p> <p>According to the Daily Get Up List, Resident #10 was scheduled to be up daily during the day shift. Resident #10 not observed out of bed on all days of the survey.</p> <p>The 06/23/13 Activity Progress Note indicated the resident "requires escort to all activities", and listed a goal of small group sensory program.</p> <p>In an interview on 07/12/13 at 10:06 a.m. Staff W, the nursing aide assigned to the resident on Day shift said she had been assigned Resident #10 on 07/10, 07/11 and 07/12/13 and did not assist the resident up out of bed nor did she plan to.</p> <p>In an interview on 07/12/13 at 9:29 a.m. Staff X, Shower Aid, said he assisted Resident #10 from the bed into a shower via a gurney and back to bed. Staff X said other than for the shower, he had not seen Resident #10 out of bed.</p> <p>In an interview on 07/12/13 at 10:02 a.m. Staff V, Activity Assistant, said she had seen Resident #10 up on shower days, but "I don't ever recall ever having him in a group."</p> | F 248 | | |

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PRINTED: 07/30/2013
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| F 248 | <p>Continued From page 14</p> <p>In an interview on 07/15/13 at 10:00 a.m. Staff O said Resident #10 got up "sometimes, but I don't know how often. They do it when they clean the rooms."</p> <p>In an interview on 07/15/13 at 9:29 a.m. Staff U reviewed Resident #10's July participation record and said the resident had not attended any group activities. Staff U was unable to recall when Resident #10 had last been in a group and commented, "I'd have to review his chart, in the last month or so... that's been an ongoing thing trying to get everyone up for the groups, but it's in progress."</p> <p>In an interview on 07/16/13 at 10:06 a.m. Staff F said Resident #10 "should be getting up during the day, and he has his own chair." When asked why Resident #10 had not been observed out of bed, Staff F replied, there was "no medical reason why not".</p> <p>RESIDENT #71 In an interview on 07/09/13 at 10:00 a.m., Resident #71 stated he did not participate in any of the activities offered at the facility.</p> <p>According to the admission MDS, dated [REDACTED]/13, Resident #71 was assessed with adequate hearing, clear speech, able to understand and be understood, with no cognitive deficits or behavioral symptoms. He was assessed as totally dependent on staff for bed mobility, dressing, transferring and personal hygiene, related to a diagnosis of a [REDACTED]. He was able to utilize a motorized wheelchair once he was placed in it.</p> <p>The Initial Activity Evaluation, dated 05/24/13,</p> | F 248 | | |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505311 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 07/16/2013 |
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| F 248 | <p>Continued From page 15</p> <p>identified the resident was active in his religion, enjoyed movies and TV, classic rock, reading and dog visits. The Admission MDS assessed it was "Very important" for the resident to have books, listen to music, be around animals, go outside, and do favorite activities. It was "Somewhat important" he participate in religious services or practices.</p> <p>Review of the May, June and July 2013 Activity Participation Records identified the resident was offered, and refused a spiritual/religious program on 06/05/13. There was no other indication he was offered a religious activity since admission. In addition, there was no indication the resident had participated in any facility activity since admission.</p> <p>The Activities Care Plan, dated 05/24/13, did not identify either a problem or a strength for the resident. It did note the resident preferred activities in the setting of his own room and day/activity areas inside the facility. The goals identified were for the resident to attend at least one activity of choice per week and to engage in independent activities of choice daily. Interventions included remind and encourage resident to attend activity they enjoy, encourage resident to assist in planning the activity program as capable, room visits when not going to activity, consult with resident for activity they prefer, provide resident with activity supplies for in room use as needed and current interests were watching TV, reading books, religion, visiting and music.</p> <p>In an interview on 07/15/13 at 10:35 a.m., Resident #71 was observed in his room, in bed with the television on. When asked about his daily</p> | F 248 | |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/30/2013
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| F 248 | <p>Continued From page 16</p> <p>routine, including activities offered he stated, "it's boring This is the most boring place on earth." He stated activities designed for "younger people" would be something he might enjoy. He stated he met someone he believed might have been the chaplain on one occasion, but as she did not know much about his denomination he did not find her particularly helpful. He stated he was unable to attend his church due to transportation issues, and that his pastor visited once but "it's a long drive." He stated no one at the facility had offered to assist him to locate a church of his denomination closer, or to determine if there might be a pastor nearby who could offer support specific to him.</p> <p>Resident #71 further stated most of the activities seem geared for an "older population" to which he did not belong. He stated he might enjoy a DVD player, or something on which he could watch movies, as he spent a great deal of time in bed and the TV channels were limited. He stated he was not aware of the availability of Books on Tape and "was not sure" if he would enjoy them or not, but that they had not been offered.</p> <p>Resident #71 stated while activity staff provided him with a monthly calendar and stopped in almost every weekday to tell him what was scheduled for that day, he had not participated in any group activities since his admission. He also stated no one had inquired about what else he might be interested in, given his lack of participation.</p> <p>In an interview on 07/16/13, the Activity Director, Staff U stated Resident #71 was independent once he was in his wheelchair. He said the resident often left the facility during the day and</p> | F 248 | | |
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AUG 12 2013

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| F 248 | Continued From page 17 watched TV in his room, Staff U stated the resident was invited to activities but had not attended any. He further stated he was not aware the resident's pastor was unable to visit or that the resident was not able to attend his church. He said the facility could contact the resident's church to ask if there were local volunteers or another church of the same denomination that the resident could attend or receive support from. Staff U stated he had not discussed the resident's spiritual preferences or needs with him, and was not aware of whether the chaplain or other facility volunteers had visited or offered support. Staff U further explained he would visit with the resident and "brainstorm with him" regarding potential activities the resident might enjoy. Failure to identify activities that might interest the resident, connect with community entities to meet the resident's spiritual needs and to provide assistance with supplies placed this resident at risk for continued boredom and frustration. | F 248 | | | |
| 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; | F 272 | F 272 COMPREHENSIVE ASSESSMENTS Plan of Correction 1. Resident #8 hearing and dental status have been reassessed, Care plans, nursing care directives and MDS have been reviewed and any discrepancies have been corrected Resident #8 has been referred to a dentist. Resident #71 has been discharged from the facility. Resident #16 pain management has been reassessed, care plans, nursing care directives, and MDS have been reviewed and any discrepancies have been corrected. | 8/22/13 RECEIVED AUG 12 2013 DSHS/ADSA/RCS | |

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| F 272 | <p>Continued From page 18</p> <p>Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to accurately assess four (#s 8, 71, 16, 96) sampled residents of the 25 residents who were included in the Stage 2 review. Failure to accurately assess residents for communication, dental status, pain and pressure ulcers placed these residents at risk for unidentified and/or unmet needs.</p> <p>Findings include:</p> | F 272 | <p>Resident #96 skin assessment and MDS have been reviewed and any discrepancies have been corrected.</p> <p>2. Residents most current hearing, dental and pain comprehensive assessments have been reviewed for accuracy, Any discrepancies have been corrected. Any needed referrals have been made.</p> <p>3. Staff have been re-educated by the Director of Nursing on completion of assessments and accurately documenting plans of care according to assessment findings.</p> <p>MDS Coordinator has been re-educated by the nurse consultant on performing and completing comprehensive assessments & resident MDS assessments.</p> <p>4. Director or Nursing and or designee will randomly audit resident MDS assessments and nursing assessments for accuracy for 3 months. Findings will be forwarded to the Executive Director</p> <p>Quality Assurance Committee will ensure compliance</p> <p style="text-align: right;">8/22/13</p> |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 272 | <p>Continued From page 19</p> <p>RESIDENT #8 According to the 03/28/13 and 06/28/13 Minimum Data Set assessments (MDS), Resident #8 had no chewing problems, was [REDACTED] and did not have loose dentures. This MDS also indicated the resident had highly impaired hearing, the absence of useful hearing and required the use of a hearing aid. She was also assessed to understand and be understood in conversation and to be cognitively intact with no memory problems.</p> <p>HEARING Observation on 07/10, 11, 12 & 15/13 revealed the resident did not utilize hearing aides.</p> <p>Review of the Aide directive, which according to Staff G (Resident Care Manager) was part of the Care Plan (CP), revealed the resident had hearing impairment on both right and left left sides but no hearing aides. She was also noted, according to the Aide directive, with upper and lower dentures.</p> <p>In an interview on 07/15/13 at 8:50 a.m. Staff I, the Nursing Assistant caring for the resident, stated, "No, she doesn't have hearing aides, she hears ok, a little hard of hearing, but you can talk with her...". Staff I indicated the resident could understand when staff verbally communicated. Staff I also stated, "she doesn't wear her teeth, its hard to understand her... her talking because she doesn't wear her teeth."</p> <p>In an interview on 07/15/13 at 9:01 a.m. Resident #8 stated, "No I don't have hearing aides...". The resident further indicated she had never had hearing aides but did want dentures that fit.</p> | F 272 | <p>RECEIVED AUG 12 2013 DGM/AS/ARDS</p> | |

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| F 272 | <p>Continued From page 20</p> <p>In an interview on 07/15/13 at 9:05 a.m. Staff G stated, "(the resident) can hear you, I haven't had any problems, if you face her she can hear you... an absence of useful hearing? no (she does not have an absence of useful hearing)... she can communicate... I have not known about her having hearing aides... let me check... she does not have hearing aides...". Staff G indicated the MDS was inaccurate as the resident did have useful hearing and did not utilize hearing aides.</p> <p>DENTURES Observations on 07/10, 11 & 12/13 revealed a dry denture cup at the resident's bedside which contained what appeared to be an upper denture plate noted with crusted food debris.</p> <p>Record review revealed an 11/13/12 dental exam which documented the, "hospital lost dentures" and "(Resident) would like new dentures" and "doctor recommends" "new dentures upper /lower." There was no further documentation addressing the resident's missing dentures until an 03/05/13 dental exam which indicated the resident was "edentulous" and "has upper denture but doesn't wear it...". This document indicated the resident was "not a good dental candidate for dentures" but did not explicate why or what changed from the 11/13/12 exam. There was no further documentation addressing the resident's missing lower dentures until an 07/02/13 dental exam in which dental staff documented the resident had "u/l (upper/lower) denture" and "(Resident) says she has lower (denture) but doesn't wear it... says she would like new dentures." There was a subsequent recommendation for new dentures.</p> | F 272 | | |

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| F 272 | <p>Continued From page 21</p> <p>In an interview on 07/12/13 at 9:35 a.m. Staff G stated she was not aware of the resident having both upper and lower dentures. Observation on 07/12/13 at 9:40 a.m. revealed Staff G picked up the denture cup from the resident's bedside and discovered the denture was stuck to the bottom of the cup, stating "this is not how we store dentures." When Staff G asked about the lower dentures, Resident #8 stated, "they're in my purse, they don't fit." The resident was able to access her purse, which was under her bed, and then produced the other half of the set of dentures.</p> <p>In an interview on 07/15/13 at 8:33 a.m., Staff E (MDS Coordinator) stated, "I think she no longer wears them (dentures)... she has dentures, doesn't like to use (them)...". When asked why the resident did not wear the dentures, Staff E stated, "she just doesn't like to is what the staff says, I don't know why she doesn't wear them... I don't know... if they were loose or broken... I didn't ask her why she didn't wear the dentures... I go by what the staff tell me... I interview both the Licensed Nurses and the Aides, I try to gather all the information from all the sources that I can...". When asked about the documentation regarding missing dentures Staff E stated, "I didn't know that she was missing dentures." Staff E confirmed she did not assess the resident as having loose or ill fitting dentures because she failed to assess the reason why the resident did not wear them. Failure to accurately assess the resident's dental status placed the resident at risk for delay in receiving dental services and altered communication.</p> <p>RESIDENT #71 In an interview on 07/09/13 at 10:04 a.m.,</p> | F 272 | | | |

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| F 272 | <p>Continued From page 22</p> <p>Resident #71 stated he had a "broken tooth" and that he needed a "crown and two (partial) bridges". On 07/15/13 at 10:30 a.m., the resident pointed to a broken tooth at the top of the left side of his mouth. He stated, "it's missing / broken, mostly missing..."</p> <p>Review of the 05/28/13 MDS indicated the resident had no dental issues including no "broken natural teeth."</p> <p>The Nutrition Evaluation Form, dated 05/30/13, identified the resident's dental status as "nat(ural)/missing".</p> <p>In an interview on 07/15/13 at 8:45 a.m., Staff E stated she relied on the Admission Nursing Assessment for the dental section of the MDS. She stated she had not examined the resident's dental status herself. She was unaware the resident had a broken tooth or dental issues that required the services of a dentist.</p> <p>RESIDENT #16</p> <p>According to the 06/26/13 MDS the resident received PRN (as needed) [redacted] medication, but no non-medication [redacted] interventions.</p> <p>Review of the June 2013 Pain Management Flow Sheet (PMFS) revealed staff attempted non-medication [redacted] interventions of environmental stimulation on four of the five days of the observation period.</p> <p>In an interview on 07/15/13 at 12:06 p.m. Staff E reviewed the PMFS and commented, "I didn't notice that (they had attempted non-drug interventions). I don't know why, it's pretty obvious."</p> | F 272 | <p>RECEIVED</p> <p>AUG 12 2013</p> <p>DSHSIADSA/RCS</p> |

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| F 272 | Continued From page 23 RESIDENT #96 According to the 05/06/13 MDS the resident was assessed with a pressure ulcer which was unstageable due to coverage of the wound bed by slough and/or eschar, which measured 2.0 cm x 2.0 cm. The 05/06/13 Skin Integrity Evaluation (Braden Scale) indicated the resident did not have any pressure ulcers, but was at high risk. In an interview on 07/12/13 at 10:16 a.m. Staff F said the resident had only had one wound on the [REDACTED] of the resident's [REDACTED] which was not a pressure ulcer. Staff F said the resident had never had a pressure ulcer. In an interview on 07/12/13 at 12:30 p.m. Staff D reviewed the resident's record and said there were no pressure ulcer evaluations, which would have been present had the resident had a pressure ulcer. In an interview on 07/15/13 at 12:06 p.m. Staff E said the wound referred to on the MDS was a pressure ulcer on the resident's left lateral malleolus. Staff E indicated she obtained the information "from the clinical record. I review all sources of skin." When asked if she had observed the wound, Staff E replied "No, all I have is what I found in the chart." The facility failed to accurately assess a wound on the MDS. | F 272 | |
| F 279 SS=E | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. | F 279 | RECEIVED AUG 12 2013 DSHS/ADSA/RCS |

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| F 279 | <p>Continued From page 24</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to develop and/or revise comprehensive care plans for eight (#s 33, 86, 105, 109, 26, 16, 80 & 96) sampled residents of the 25 residents who were included in the Stage 2 review. Failure to establish care plans that accurately reflected assessed care needs and provided direction to staff on the residents' care related to device use, dental status, discharge, nutrition, pain, psychotropic medications and pressure ulcers placed residents at risk to receive less than adequate care.</p> <p>Findings include:</p> <p>RESIDENT #33 Resident #33 was admitted to the facility with</p> | F 279 | <p>F 279 DEVELOP COMPREHENSIVE CARE PLANS</p> <p><u>Plan of Correction</u></p> <p>1. Resident # 33 care plan has been reviewed and updated to reflect the resident's oral/dental status and discontinuation of helmet.</p> <p>Resident #86 care plan has been reviewed and updated to eliminate any staff confusion.</p> <p>Resident #105 discharge care plan has been updated to reflect the most recent desired discharge location in addition to specific goals and barriers.</p> <p>Resident #109 has been discharged from facility.</p> <p>Resident #26 End Stage Renal Disease with Dialysis care plan has been updated to reflect the discontinuation of need for staff documentation.</p> <p>Resident #16 Pain Management Care Plan has been written.</p> <p>Resident #80 Psychotropic Medication, Depression and Anxiety care plans have been written.</p> | <p>RECEIVED AUG 12 2013 DSHS/ADSA/RCS</p> |
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| F 279 | <p>Continued From page 25</p> <p>diagnoses of [REDACTED], [REDACTED] and [REDACTED]. According to the 07/08/13 Minimum Data Set assessment (MDS) the resident required limited one person physical assistance with transfers and personal hygiene.</p> <p>According to Resident #33's Care Directives (the portion of the Care Plan which directs nursing aides how to provide care to a resident), Resident #33 required the use of a helmet. Observations on 07/11, 12 & 15/13 revealed the resident either lying in bed or up in his wheelchair, however no helmet was seen during these observations.</p> <p>In an interview on 07/16/13 at 8:35 a.m. Staff G (Resident Care Manager; the licensed nurse responsible for the care of the residents on the unit and who supervises the care provided to residents by Nursing Assistants) stated, "He doesn't need a helmet, he hasn't needed that for a while, he had [REDACTED] on [REDACTED] so he doesn't need it (helmet) anymore". Failure to ensure the care plan (CP) was updated to accurately reflect the assessed needs placed the resident at risk for unnecessary services.</p> <p>Additionally, according to Resident #33's Nutrition status CP dated 06/18/13, the resident was identified with "oral/dental issues, (no) teeth."</p> <p>However, according to dentistry forms dated 01/18/13, 04/24/13, and 05/07/13, the resident was identified with broken, carious teeth. Observation on 07/08/13 at 12:46 p.m. revealed the resident had broken/missing teeth. Failure to ensure the CP accurately reflected the resident's oral/dental status placed Resident #33 at risk to not receive necessary care.</p> | F 279 | <p>Resident #96 Alteration in Skin Integrity care plan has been reviewed and updated to reflect resolution and correct wound type.</p> <p>2. Residents care plans have been reviewed for completion and accuracy and updated as needed</p> <p>Staff have been re-educated by the Director of Nursing to update resident care plans as changes in residents plan of care occur and quarterly.</p> <p>3. Care plans will be randomly audited by the Resident Care Managers for 3 months. Audit results will be forwarded to the Executive Director.</p> <p>4. Quality Assurance Committee will ensure compliance.</p> | |

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| F 279 | <p>Continued From page 26</p> <p>RESIDENT #86 Resident #86 was admitted to the facility in [REDACTED] 12 with diagnoses related to a [REDACTED]. According to the 06/10/13 MDS the resident was assessed to "sometimes understand(s) responds adequately to simple direct communication only" and had moderately impaired decisions making, "decisions poor, cues/supervision required."</p> <p>Observations on 07/10/13 at 1:10 p.m. revealed the resident lying in bed, watching TV. The resident was able to state what program he was watching but was unable to answer questions regarding his care.</p> <p>According to the resident's CP, he was in a current sexual relationship with his partner. According to Social Services notes dated 12/18/12 the resident's partner, "informs this Social Worker that he and (resident) are now "just" friends and no longer are in an intimate relationship." In an interview on the morning of 07/11/13, Staff B indicated the CP was outdated as the resident was no longer in a sexual relationship. Staff B further stated the CP should have been updated to reflect this change. Failure to ensure CPs were accurate had the potential to cause confusion to staff, who would be unable to provide accurate care.</p> <p>RESIDENT #105 Resident #105 admitted to the facility in the beginning of [REDACTED] 13 following a [REDACTED] for [REDACTED]. He completed radiation therapy in 05/13 and was "deemed appropriate" for discharge according to a 05/06/13 Social Service (SS) note. The 05/08/13 quarterly SS note identified the resident as "well-suited to live independently" despite substantial medical</p> | F 279 | |

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| F 279 | <p>Continued From page 27 needs.</p> <p>The Discharge CP, dated 05/09/13, identified the goal of "Res(ident) will discharge to ALF (assisted living facility) vs. SNF (skilled nursing facility); other (independent living - voucher program?". The approaches did not include any specific barriers to discharge, nor did it indicate what specific goal had been set following the May 2013 physician and SS notes. There was no indication of what the discharge plan was or what needed to occur for it to be realized.</p> <p>In an interview on 07/15/13 at 12:40 p.m., Staff N, Social Services Director, stated the resident planned to discharge to an independent setting once resources were in place through the State. He acknowledged the care plan should have been updated to include the discharge location in addition to specific goals and barriers.</p> <p>RESIDENT #109 Similar findings were identified for Resident #109 for whom a discharge care plan was not updated as his goals changed to include specific barriers to discharge and a change in the discharge location. The Discharge CP, dated 05/21/13, identified the goal that the resident would discharge to an independent setting with his family. Approaches identified were not specific regarding what the resident needed to accomplish in order to reach the identified goal. In addition, according to an 05/21/13 SS note, the resident's goal was to discharge to an in-patient rehabilitation setting. Subsequent notes identified barriers to that goal, however neither the change in goal or the barriers to discharge were identified in the care plan. In an interview on 07/15/13 at 12:45 p.m., Staff N stated the care plan should</p> | F 279 | | |
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|--------------------|--|---------------|---|----------------------|

F 279 Continued From page 28
have been updated to identify the change in the resident's goal, as well as with specific approaches in order to help the resident reach his goal.

RESIDENT #26
The [REDACTED] with [REDACTED] CP, dated 04/24/13, identified a goal of "maintain fluid restrictions". Interventions included "fluid restriction of 900 ccs (cubic centimeters) per day (600 meals and 300 nursing)".

The Fluid overload CP, dated 09/28/12, identified an approach of "maintain fluid restriction".

Review of Physician's Orders (PO) revealed the resident's fluid restriction was discontinued on 03/06/13.

In an interview on 07/15/13 at 11:20 a.m., Staff G acknowledged the resident no longer had a fluid restriction and that the care plans should have been updated to reflect his current status.

In addition, the [REDACTED] CP indicated the resident would not have tray monitors conducted, however staff regularly completed them for each meal. Staff G stated the care plan should reflect what staff were actually doing.

RESIDENT #16
On 07/11/13 at 8:23 a.m. Resident #16 was observed awake in bed, with a facial grimace, clenching his teeth and periodically reaching up in the air with his hands.

According to the 06/26/13 MDS, the resident was assessed as without speech, rarely/never understood or understands, received PRN (as

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| F 279 | <p>Continued From page 29 needed) [redacted] medications and communicated [redacted] by facial expressions and other indicators of [redacted] which were observed daily.</p> <p>Record review revealed a 05/29/13 PO to irrigate and cover the resident's [redacted] wound each day shift. This procedure could be expected to cause pain or discomfort. In addition, the resident had an 05/30/13 PO for pain medication [redacted] every six hours as needed for [redacted].</p> <p>Review of the June 2013 Medication Administration Record (MAR) noted frequent use (33 times) of PRN [redacted] for signs and/or symptoms of pain. Staff assessed the resident's [redacted] at level 6 (on a scale of one to ten with ten being the worst pain imaginable) on 6/23/13, 6/24, 6/28, and 6/30/13. The documented reason for [redacted] included "general discomfort" and [redacted].</p> <p>The Pain Management Flowsheet indicated non verbal signs of pain at a level 3 frequently on day shift and at a level 4 occasionally on evening shift.</p> <p>In an interview 07/15/13 at 11:00 a.m. Staff F said Resident #16 had a pressure ulcer to his [redacted] [redacted] into the arch of his foot, and did not complain of pain during the dressing changes. Staff F said Resident #16 was able to tell staff when he experienced pain, and if he was not then staff were to perform a non verbal assessment of pain. Staff F said Resident #16 "does have [redacted] available to him," "Pain is not an issue, but he has pain medication which he uses at times."</p> <p>The 06/28/13 Alteration in Skin Integrity CP</p> | F 279 | | |
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| F 279 | <p>Continued From page 30 related to pressure [REDACTED] [REDACTED] did not address pain or include pain relief approaches. There was no Potential for, or Actual Pain CP.</p> <p>Staff F verified there was not a plan of care related to pain management for Resident #16 and since the resident received pain medication he should have one in place.</p> <p>In an interview 07/15/13 at 11:00 a.m. Staff F commented, "No, there is not a care plan for pain, that is probably a fault of mine."</p> <p>RESIDENT #80 According to the 06/27/13 MDS, the resident had a diagnosis of [REDACTED] and received [REDACTED] medication daily. Review of the resident's record revealed an 03/29/13 PO for [REDACTED] as needed for [REDACTED] and [REDACTED] as needed for [REDACTED].</p> <p>Further review of the resident's record on 07/15/13 revealed there was no CP for [REDACTED] medications, [REDACTED], [REDACTED], [REDACTED], and/or [REDACTED]. In an interview on 07/16/13 at 8:31 a.m. Staff N indicated he must have missed them and that there should be CPs in place.</p> <p>RESIDENT #96 According to the 05/19/13 Alteration in skin integrity CP the resident had a pressure ulcer to his [REDACTED]. The listed goal was "resident will remain free of s/s of infection until healed". Approaches listed included keep off [REDACTED] [REDACTED] protect heels (float off mattress or use pressure relieving mattress), and weekly skin evaluation.</p> | F 279 | | |

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| F 279 | Continued From page 31 The second floor Skin Binder had an 05/21/13 "Non-Ulcer Evaluation" for Resident #96's [REDACTED] which was measured weekly, decreased in size, improved and was noted to have resolved on 07/02/13. On 07/16/13 at 10:16 a.m. the resident's lower extremities, including ankles, were observed with Staff F. The skin was intact. Staff F said Resident #96's outside ankle wound was resolved. He said the wound had not been a pressure ulcer which is why it was monitored on the Non Ulcer Evaluation Form. Staff F acknowledged that information should have been reflected on the CP. The facility failed to correctly identify the wound type on the CP and failed to revise the plan of care when the wound resolved. | F 279 | |
| F 314 SS=D | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to | F 314 | <p>F 314 TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p><u>Plan of Correction</u></p> <p>1. Resident #1 newly developed skin issue has been treated per physician orders.</p> <p>Resident #1 Alteration in Skin Integrity Care Plan has been reviewed and updated to reflect treatment, alternative interventions and family behavior of removing protective equipment</p> <p>2. Residents' skin integrity will continue to be assessed on a weekly or bi-weekly schedule by a Licensed Nursing Staff and daily by Certified Nursing Assistants.</p> <p>Any identified issues will be communicated to the resident's primary physician. Physician orders and directives will be care planned accordingly.</p> <p style="text-align: right;">8/22/13</p> |

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| | <p>Continued From page 32</p> <p>implement interventions consistent with resident needs, identify and report alteration in skin integrity; and to monitor, evaluate and or revise interventions as appropriate upon identifying barriers to these interventions for one of three residents (#1) of the four residents who were identified with pressure ulcers during the Stage 1 staff interview. This failure had the potential to cause harm to Resident #1 who developed a pressure sore after admission.</p> <p>Findings include:</p> <p>According to the facility skin integrity guidelines, staff were to "reposition every two hours or per individualized schedule", and "elevate heels off of bed surface and use pillows between knees". Further, "Pressure ulcer precautions are included to assist in providing a consistent interdisciplinary approach to treatment".</p> <p>RESIDENT #1</p> <p>According to the Admission Minimum Data Set assessment (MDS) dated 05/07/12, Resident #1 admitted to the facility with diagnoses [REDACTED], [REDACTED], and [REDACTED]. This MDS indicated the resident had an unstagable pressure ulcer and was at risk for the development of pressure ulcers (PUs). The 07/15/13 MDS indicated the resident had a [REDACTED], was at risk for the development of further pressure ulcers and was totally dependant on two staff for bed mobility.</p> <p>According to the "alteration in skin integrity" Care Plan (CP), dated 02/04/13, the resident had an identified sacral ulcer and staff were directed to "Protect Heels (float off mattress or use pressure</p> | | <p>3. Staff have been re-educated on how to identify skin integrity concerns and facility procedures for reporting any concerns.</p> <p>Family education will occur by the Resident Care Mangers or designee when need is identified on the how the removal of care planned interventions may be harmful to the residents.</p> <p>4. Director of Nursing will perform random skin integrity rounds/audits to ensure accuracy to care plans and skin checks. Findings will be forwarded to the Executive Director.</p> <p>Quality Assurance Committee will ensure compliance</p> | |

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| F 314 | <p>Continued From page 33</p> <p>relieving mattress)", utilize "heel protectors" and perform, "daily skin check during care."</p> <p>Observation on 07/10/13 at 8:45 a.m. revealed the resident lying in bed on her back, slightly to the right. The resident was noted at that time not wearing boots (heel protectors). The resident's legs were noted to be together with knees pulled up toward the chest. Similar findings were identified at 11:22 a.m. and 11:51 a.m. The resident was noted at 1:15 p.m. to be wearing blue heel protectors. The resident was ventilator dependant and unable to participate in interview.</p> <p>Observation on 07/11/13 at 8:45 a.m. revealed Resident #1 lying in bed on her back, positioned slightly to the left. The resident was not wearing blue boot/heel protectors at that time.</p> <p>Observation at 10:22 a.m. revealed the resident in bed on her back with no blue boots/heel protectors worn by the resident at that time.</p> <p>The resident's daughter, who was at the bedside, stated at 10:24 a.m., she was concerned about her mother's foot and proceeded to show survey staff the resident had a blister to the [REDACTED]. The resident was noted with legs together, knees pulled up toward the chest and the left foot was noted on top of, and in direct contact with the resident's [REDACTED]. According to the daughter, "I found that the other day, I told them (staff) about it...". Record review revealed no indication staff were aware of, or treating the heel wound.</p> <p>Similar observations at 11:55 a.m. revealed the resident was not utilizing the blue boots/heel protectors.</p> <p>In an interview at 12:01 p.m. on 07/11/13 Staff F,</p> | F 314 | | |

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| F 314 | <p>Continued From page 34</p> <p>the Resident Care Manager, indicated he was not aware of a [REDACTED] on Resident #1's [REDACTED] and no staff had reported any skin issues for Resident #1. Observation on 07/11/13 at 12:04 p.m. confirmed the presence of what Staff F described as a "3.5 centimeter (cm) x 4 cm fluid filled blister" on the resident's [REDACTED] describing it as a "Stage II" pressure ulcer. Staff F confirmed at that time Resident #1's CP was not being implemented, as the resident was not currently utilizing blue boots/heel protectors. Staff F proceeded to retrieve heel protectors from the resident's closet. In additional conversation, Staff F indicated he expected direct care staff (those staff who provide direct care on a regular basis, including Nursing Assistants and/or Restorative Aides) to report any alteration in skin integrity, that he should be aware of any resident pressure ulcers and staff should implement the interventions identified on the CP.</p> <p>On 07/11/13 at 1:01 p.m., Staff O (Restorative Aide) was observed to initiate Range of Motion (ROM) exercises for Resident #1. Staff O was observed to range the resident's upper and lower right extremity, including grasping Resident #1's right heel and ranging the ankle.</p> <p>In an interview at 1:15 p.m. on 7/11/13, Staff O was asked if she noticed anything about Resident #1's right foot. Staff O stated she didn't notice anything about Resident #1's foot. Staff O elaborated that she did ROM for Resident #1 yesterday and didn't notice anything about the right foot at that time either. Failure of direct care staff to identify and report skin issues placed the resident at risk for delayed identification and treatment of pressure ulcers.</p> | F 314 | |

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| F 314 | Continued From page 35 In an interview on 07/15/13 Staff B (Director of Nursing Services) indicated staff were aware the resident's daughter would remove the heel protectors stating, "if she thinks her (the resident's) feet are hot she takes off the boot and tells the aides not to put them on... we say the resident or family is always right... I can tell you that (it was mentioned) during report (the) daughter takes off boots then the aides will reapply after she leaves... I know that Staff F has had many discussions about these sort of things... hopefully there will be something in the (care conference) notes...". Record review revealed no mention of family removing Resident #1's heel protectors. While staff verbally indicated an awareness family removed the heel protectors, there was no indication in the record of family education that the removal of care planned interventions might be harmful to the resident. There was no indication in the record alternative interventions were developed to prevent heel ulcers (i.e. floating heels). Staff B also indicated, "If a resident has care plan interventions, that staff (should) implement them, and if they don't they report to the charge nurse...". Failure to develop interventions for an issue (family removing heel protectors) which negated care planned interventions placed the resident at increased risk for developing a PU. | F 314 | | | |
| F 329 SS=E | 483.25(I) 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 | F 329 | | | |

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| F 329 | <p>Continued From page 36 duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to ensure residents received adequate monitoring of medications, medications only as ordered, as needed medications separately, or gradual dose reductions for six (#s 86, 49, 71, 80, 28 & 17) of ten residents reviewed for unnecessary medications of the 25 residents who were included in the the Stage 2 review and one (#74) supplemental resident. These failures placed residents at risk for adverse side effects or to receive unnecessary medications.</p> <p>Findings include:</p> | F 329 | <p>F 329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p><u>Plan of Correction</u></p> <p>1. Resident #86 Behavior Monitoring Flow Sheet has been updated to reflect ruling out pain prior to the administration of the as needed anti-anxiety medication.</p> <p>Resident #86 Bowel medication orders and medication administration records have been reviewed for accuracy.</p> <p>Resident #49 Behavior Monitoring Flow Sheets have been implemented for the use of their anti-psychotic and anti-anxiety medication. Care plan has been updated to reflect target behaviors for the use of the previous medication.</p> <p>Resident #49 bowel and insulin medication physician orders have been reviewed and revised as ordered by physician.</p> <p>Resident #71 has been discharged from the facility.</p> <p>Resident #80 Behavior Monitoring Flow Sheets have been implemented to include non-drug interventions.</p> <p style="text-align: right;">8/22/13</p> |

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| F 329 | <p>Continued From page 37</p> <p>RESIDENT #86 Resident #86 was admitted to the facility in [redacted]/12 and according to the 06/10/13 Minimum Data Set assessment (MDS), had an [redacted] and was assessed to both experience pain and demonstrate behaviors not directed toward others (e.g., ...verbal/vocal symptoms like screaming, disruptive sounds).</p> <p>Observations throughout the survey revealed Resident #86 lying in bed, either watching TV, listening to the radio or napping. The resident was unable to answer direct questions about care received in the facility.</p> <p>According to the resident's care plan (CP) for [redacted] use, interventions included: "non-pharmaceutical interventions as needed... assess for possible pain, discomfort...". According to facility Behavior Monitoring Flow Sheets (BMFS), staff identified the resident required the use of as needed (prn) [redacted] medications for "calling/yelling out, [redacted] onset and intense weeping." Non drug interventions included "reassure safety, reassure family will return, validate feelings, and attempt to redirect focus." While the CP directed staff to assess for possible pain, there was no intervention on the BMFS which addressed ruling out pain prior to the administration of prn [redacted] medication.</p> <p>Review of April Medication Administration Records (MARs) revealed on 04/17/13 at 0610 the resident received prn [redacted] (a [redacted] reliever) and [redacted] (an [redacted]) for "increased yelling, back pain" and "increased yelling/anxiety." Similar findings were identified for</p> | F 329 | <p>Resident #80 medication regimen has been reviewed by the Psychotropic Committee. All recommendations have been reviewed by the primary physician for any changes in orders. Resident has been notified.</p> <p>Resident #28 has been discharged from the facility</p> <p>Resident # 17 anti-depression medication has been reviewed by the Psychotropic Committee and primary physician. The physicians documentation and rational for medication are noted in resident medical record.</p> <p>Medication error reports have been completed as appropriate.</p> <p>2. Residents with psychotropic medication orders will be reviewed to ensure that a Behavior Monitor Flow Sheet is present and includes non-drug interventions.</p> <p>Resident Medication Administration Records and physician orders have been reviewed to identify that bowel and insulin medications have not been administered unnecessarily. Any findings have been corrected.</p> <p>Licensed staff have been re-educated on systems to adequately</p> | 8/22/13 |

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| F 329 | <p>Continued From page 38</p> <p>04/16/13 at 0630, 04/17/13 at 1800, 04/19/13 at 0001, 04/24/13 at 0000, 04/25/13 at 0000, and 04/29/13 at 1800. There was no indication staff ruled out pain or considered the pain as a contributing factor to the yelling/anxiety prior to the administration of the prn [REDACTED].</p> <p>Review of May 2013 Medication Administration Records (MARs) revealed staff concomitantly administered [REDACTED] and [REDACTED] on 05/03/13 at 0000 for "increased yelling/grimacing" and "increased yelling/anxiety." There was no indication staff attempted to rule out pain as the catalyst for anxiety. Similar findings were identified when staff administered [REDACTED] and [REDACTED] medications together on 05/01/13 at 1800, 05/06/13 at 1900, 05/10/13 at 1900, and 05/27/13 at 1700. Failure to rule out and/or treat pain as a contributing factor to anxiety prior to administration of prn anti-anxiety medication constituted the use of unnecessary medication.</p> <p>Staff G (Resident Care Manager, responsible for the coordination of resident care), in an interview at 1:48 p.m., stated, "yes we do non-drug interventions prior to the administration of prn [REDACTED] medications." Staff G indicated Resident #86 was capable of verbalizing where he experienced pain stating, "I would give the pain medication (first), if he says no pain, and they've exhausted all non-drug interventions then they give... [REDACTED] (medication)." Staff G was unable to explain why staff would give both [REDACTED] and [REDACTED] medications at the same time without first ruling out pain as a contributing factor to the [REDACTED]. Failure to identify, address, and eliminate or reduce underlying causes of distressed behavior (pain), prior to the</p> | F 329 | <p>monitor medications, administer medications only as ordered and as needed medications separately. Social Services staff have been re-educated on the systems of monitoring behaviors for medications appropriately and guidelines of general dose reductions.</p> <p>3. Psychotropic Committee members will audit resident psychotropic medications, presence of behavior monitor flow sheets and target behaviors randomly for 3 months to ensure accuracy and quarterly thereafter. Audit results will be forwarded to the Executive Director.</p> <p>Resident Care Managers will review physician orders and Medication Administration Records monthly to ensure no unnecessary medications as being administered and for accuracy. Any findings will be forwarded to the Director of Nursing.</p> <p>4. Quality Assurance Committee will ensure compliance.</p> <p>8/22/13</p> |

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F 329 Continued From page 39
administration of prn [REDACTED] medication constitutes the use of an unnecessary drug.

BOWEL MEDICATIONS
According to Physician Orders (POs), staff were directed to administer Milk of Magnesium (MOM) if the resident had no BM (Bowel Movement) for two days. There was an additional order for a [REDACTED] to be given "on day #3 if MOM is not effective (for [REDACTED])."
According to June 2013 MARs Resident #86 received a [REDACTED] on the night shift of 06/06/13 "for no bm x 3 days". There was no indication the resident was given MOM, as the PO directed, prior to the more invasive suppository.

In an interview on 07/10/13 at 1:48 p.m., Staff G indicated if the MOM, which was ordered to be given first, was not effective then the suppository should be given. Staff G stated, "yeah, absolutely, they should have given the MOM (first)... they should have followed the physician orders...". Administration of the suppository when it was neither ordered nor required constituted the use of an unnecessary drug.

RESIDENT #49
Resident #49 was admitted to the facility with a diagnosis of [REDACTED] and multiple [REDACTED]. According to the 06/20/13 MDS, Resident #49 demonstrated no psychosis, no behavioral symptoms, and no rejection of care.

According to current POs, the resident had orders for as needed [REDACTED] medication ([REDACTED]) and received a regularly scheduled [REDACTED] medication. Record review revealed no

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| F 329 | <p>Continued From page 40</p> <p>monitoring of Target Behaviors (TBs) in the current MAR, or with the June or May MARs. In an interview on 07/10/13 at 9:54 a.m., Staff F (Resident Care Manager, responsible for the coordination of care for residents) confirmed the absence of behavior monitoring, stating, "there should be (TB sheets)". Staff F indicated staff documented the following on TB monitoring records: Resident behaviors, non-drug interventions and effectiveness of interventions. Failure to monitor behaviors which required the use of anti-psychotic and anti-anxiety medications constitutes the use of unnecessary drugs.</p> <p>In an interview on 07/10/13 at 11:00 a.m. Staff N (Social Service Director) indicated the resident had repetitive anxious complaints but was unable to provide TB documents which would support staff attempted non drug interventions. Staff N indicated non drug interventions should be attempted prior to prn use and indicated if the resident had a preference for no non-drug interventions, staff would assess and care plan the issue. Record review revealed no indication staff assessed the resident did not require non drug interventions.</p> <p>Review of May 2013 MARs revealed Resident #49 received prn [REDACTED] on 05/17/13 at 2400, on 05/21/13 at 0001 and on 05/29/13 at 2345. Review of progress notes and the absence of TB sheets revealed staff failed to attempt non drug interventions prior to the administration of [REDACTED]. Administration of prn [REDACTED] medication in the absence of behaviors which require its use and without attempts at non drug interventions constitutes the use of unnecessary drugs.</p> <p>Review of June 2013 MARs revealed the resident</p> | F 329 | |

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| F 329 | <p>Continued From page 41</p> <p>received prn [REDACTED] medication on four occasions between 11:30 p.m. and 12:00 p.m., "per resident request." There was no indication in the record staff attempted non drug interventions prior to the administration of these medications.</p> <p>BOWEL MEDICATIONS According to POs, staff were directed to administer MOM if Resident #49 had no BM for two days. There was an additional order for a Bisacodyl suppository to be given "on day #3 if MOM is not effective (for constipation)." According to the MARs for May 2013, the resident received MOM on 05/22/13 at 2300 for "no bm in 2 days". Staff documented on 05/23/13 at 0400 "mom 30 mls no bm 2 days."</p> <p>In an interview at 10:02 a.m. on 07/10/13, Staff F confirmed staff gave MOM five hours after it was initially given, without a physician's order. Staff F indicated, "we usually wait eight hours after the MOM (to determine if it's ineffective)." Administration of a second dose of MOM when none was ordered constituted the use of an unnecessary medication.</p> <p>INSULIN Review of POs revealed directions to staff to assess blood sugars and administer insulin based on those results three times a day and "Hold (insulin) for (blood sugars) less than 100." Review of May 2013 MARs revealed the resident had blood sugars lower than 100 yet staff continued to administer the medication on May 3, 20, 24 and 26. Review of June MARs revealed staff administered insulin with blood sugars below 100 on June 15, 18, 21, and 29. Administration of insulin outside physician ordered parameters constituted the use of an unnecessary drug.</p> | F 329 | <p>RECEIVED AUG 17 2013 DSHS/ADSD/SA</p> |

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| F 329 | Continued From page 42 RESIDENT #71 According to the admission Psychotropic Medication Care Area Assessment (CAA), the resident utilized [REDACTED] and [REDACTED] medications. The CAA noted the resident had [REDACTED] related to his medical condition and has prn [REDACTED] ordered, which he took 4/7 days of the MDS period. He has some frustration and anger related to his diagnosis but does calm down and is actually quite nice and friendly... Please see social service section of the chart for more info." Review of the May 2013 MAR revealed the resident received prn [REDACTED] on 05/21, 22 and 24/13 for [REDACTED] related to his medical condition. On 05/21/13 the [REDACTED] was given at the same time as the narcotic pain reliever, [REDACTED]. The front of the 06/13 MAR indicated prn [REDACTED] was administered five times (twice on 6/09 and once each on 06/15, 23 and 30/13. There were no non-drug interventions noted prior to the administration of any of the prn doses. In addition, there were no behavior monitors in place since the resident's admission. The Psychotropic medication CP, dated 05/29/13, identified the resident required the use of [REDACTED] and [REDACTED] medications due to "anger/verbal abusiveness r/t [REDACTED] disorder and [REDACTED]". The goals included, "Will have an improvement in behavioral symptoms and a reduction in target behaviors". Interventions included "non-pharmaceutical interventions as needed", "monitor for behavioral symptoms", "document episodes of behavior" and "assess for possible pain, discomfort or hunger, provide interventions as needed." | F 329 | | | |

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| F 329 | <p>Continued From page 43</p> <p>In an interview on 07/15/13 at 12:20 p.m., Staff N stated there "should be a behavior monitor since the resident is on an [REDACTED]". He stated there should be non-drug interventions identified that staff should attempt prior to administration of the medication. He stated the care plan was appropriate however in order to implement it, behavior monitors needed to be in place. He was unable to explain why there were no monitors in place, since the resident's admission in [REDACTED] 2013, related to the use of the prn [REDACTED] that would justify its use.</p> <p>RESIDENT #80 Review of the resident's record revealed a 03/29/13 PO for [REDACTED] in the evening as need for [REDACTED]. Review of the June 2013 MAR revealed the [REDACTED] was administered on 06/11/13 at 10:45 p.m. for complaints of [REDACTED] and on 06/30/13 at 12:05 a.m. for complaints of [REDACTED]. Neither of these doses had documented effectiveness of the medication on the MAR. Review of the associated progress notes revealed staff did not document the attempt of non drug interventions (NDI) prior to administration of the medication. In an interview on 07/12/13 at 11:04 a.m. Staff F indicated NDIs were documented on the BMFS. Review of the record revealed no BMFS for May, June or July 2013. Staff F indicated the BMFS was implemented by Social Services. In an interview on 07/16/13 at 8:31 a.m. Staff N, Social Services Director, said he would expect behavior monitoring forms to identify and track NDIs before administering medications. He was not aware there were no BMFSs in the resident's record.</p> <p>Review of the 06/18/13 Behavior Management and Medication Review (BMMR) revealed the</p> | F 329 | | |

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| F 329 | <p>Continued From page 44</p> <p>committee recommended discontinuation of the prn [REDACTED] and adding [REDACTED] as needed for [REDACTED]. Review of the resident's record revealed no documentation to support the physician and resident were notified of the recommendation nor that it was implemented. In an interview on 07/16/13 at 8:31 a.m. Staff N said indicated the physician was present in the meeting and "I followed up and I believe she (the resident) didn't want the [REDACTED]"</p> <p>Additionally, the resident had a 03/29/13 PO for [REDACTED] as needed for [REDACTED]. Review of the June 2013 MAR revealed the [REDACTED] had been administered on 06/06/13 at 9:30 p.m. Review of the Progress Notes revealed "Resident alert and oriented. able to make needs known. c/o breathing problem x 1. Suctioned and breathing treatment given by RT (Respiratory Therapy). [REDACTED] 1 mg also given for [REDACTED]. Two [REDACTED] for back pain given with good result....". Further review of the MAR revealed staff administered two [REDACTED] on 06/06/13 at 9:30 p.m. for back pain. In an interview on 07/12/13 at 11:04 a.m. Staff F said pain and anxiety medications should not be administered concurrently and he would expect the resident's record to have a BMFS for the [REDACTED] use. Failure to rule out and/or treat pain as a contributing factor to [REDACTED] prior to administration of prn [REDACTED] medication constituted the use of unnecessary medication.</p> <p>Review of the 06/18/13 BMMR indicated the resident did not have a behavior management program in place, and staff did not identify any target behavior for the use of [REDACTED]. In an interview on 07/16/13 at 8:31 a.m. Staff N confirmed there was not a BMFS, did not know why a BMFS was not implemented after the</p> | F 329 | | |

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| F 329 | <p>Continued From page 45</p> <p>BMMR and added "she needs one." In addition, when informed staff administered [REDACTED] and [REDACTED] at the same time, Staff N said "They need to not give both."</p> <p>RESIDENT #28 According to the 05/26/13 MDS, the resident had diagnoses including [REDACTED], [REDACTED] and [REDACTED]. The resident was assessed with disorganized thinking, short tempered daily, with delusions, and exhibited the behavior of rejection of care on one to three days. According to the MDS the resident's behavior was worse than it had been at the last assessment. During the observation period the resident received [REDACTED] medication on six days and [REDACTED] medication daily.</p> <p>According to the 02/20/13 Behavior CP the resident exhibited the "Behavior Problem" of "Physically Abusive", "Verbally Abusive" as evidenced by "Striking out, Kicking, Inappropriate statements and refusal of care." One of the goals listed was occurrence of the behavior less than daily.</p> <p>Review of the BMFS revealed only one identified target behavior of "Repetitive Medical Concerns", triggered by "Feeling short of breath", with interventions of, assess respiratory function, provide resp tx if indicated, provide calm reassurance and redirect resident focus. There was no BMFS for the month of May 2013.</p> <p>Review of the progress notes since March 2013 verified that resident called out for help and experienced [REDACTED] related to his medical condition as evidenced by documented statements such as "I can't breath" which was</p> | F 329 | | | |

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| F 329 | <p>Continued From page 46</p> <p>relieved with the above NDI and prn [REDACTED]. Beginning in April 2013 the resident began to exhibit various behaviors such as on 04/01/13 "Resident refused to be changed by aids during first rounds", 04/07/13 "...possible visual hallucinations about seeing a cat...", 04/10/13 "refused vital signs.", 04/30/13 "occasionally combative during care.", 05/20/13 "delusional", 05/30/13 "struck out with a clenched fist at CNA staff twice", 05/31/13 "refused all care with ADLs", and "combative with CNA's".</p> <p>Staff documented in the progress notes administration of [REDACTED] as needed, no longer for "Repetitive Medical Concerns", but for other behaviors as evidenced by progress notes such as on day shift 07/4/13 [REDACTED] 1 mg given for continuous hitting of staff members while care was being provided, relief obtained."</p> <p>Review of the June 2013 MAR, BMFS, and progress notes revealed staff documented administration of [REDACTED] without documented behavior indicators or NDI on 10 occasions in June: 06/01/13 at 8:00 p.m., 06/02/13 at 8:00 p.m., 06/06/13 at 8:00 p.m., 06/08/13 at 8:30 a.m., 06/09/13 at 5:00 a.m., 06/10/13 1:00 p.m., 06/11/13 11:38 a.m., 06/14/13 5:00 p.m., 06/15/13 at 9:30 p.m., and 06/30/13 at 1:30 p.m.</p> <p>In an interview on 07/11/13 at 10:45 a.m. Staff S, Licensed Nurse, "sometimes he would be agitated and he would ask for an [REDACTED] and I would give it to him," "sometimes it helped sometimes it didn't", "usually it was related to his care, would tell him he needed to be changed, re-offer, sometimes an hour later he would agree, if not his wife came about 4:00 p.m. and would tell him to change. Usually the [REDACTED] helped."</p> | F 329 | | |

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| F 329 | <p>Continued From page 47</p> <p>In an interview on 07/16/13 at 8:31 a.m. Staff N said "I don't recall him being violent at all, I don't recall being notified." Staff N indicated if he had been aware he would have identified triggers and revised the behavior monitoring flow sheet.</p> <p>Administration of prn [REDACTED] medication in the absence of behaviors which require its use, and failure to monitor behaviors associated with its use, constitute an unnecessary medication.</p> <p>RESIDENT #17 Resident record review revealed a 01/24/13 Pharmacy Consultation Report which indicated the resident received [REDACTED] 10 mg daily for management of [REDACTED] symptoms since 12/2011 and recommended a gradual dose reduction (GDR), perhaps a trial discontinuation of [REDACTED] while concurrently monitoring for re-emergence of [REDACTED] and/or withdrawal symptoms. On 01/31/13 the Physician declined to implement the recommendation because "Daughter believes it helps and does not want us to stop the medication."</p> <p>According to the 05/15/13 MDS, the resident was assessed as [REDACTED] in a [REDACTED] [REDACTED], with a diagnosis of [REDACTED] for which the resident received [REDACTED] medication daily. Review of the current POs revealed the resident had been on the same dose of [REDACTED] since 12/02/11.</p> <p>A 05/15/13 SS Annual Progress Note indicated that "Any changes to this dose, including normative GDR's, are contraindicated." Resident #17 "has continued at baseline without signs of increased [REDACTED] symptoms." The note did</p> | F 329 | |

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| F 329 | <p>Continued From page 48 not indicate why the GDR was contraindicated.</p> <p>The May 2013 Psychotropic Medications CAA noted the resident "has been in an [REDACTED] state for several years now, following a [REDACTED] event in 2005... she does present with a sleep-wake cycle and her family members have seen emotional responses from her such as laughing or crying. However she does not track, follow commands, or have purposeful movement... does receive [REDACTED] as her daughter has reported signs of [REDACTED] including tearfulness, and felt that she was [REDACTED]. she did have a history of [REDACTED] in her past, before her [REDACTED]" The CAA did not address a GDR.</p> <p>The 05/15/13 Psychotropic Medication CP listed approaches of "Consult MD for drug regime change as needed" and "Evaluate for dose reduction as appropriate" by which was written "POA currently refuses GDR".</p> <p>Review of the June BMFS identified the target behavior as "increased tearfulness", which was not documented as observed. The 06/18/13 Behavior Management and Medication Review noted "Resident is minimally responsive and has been doing well with no s/sx of [REDACTED] Daughter/POA does not want to allow recommended GDR for fear of reoccurring sx. No changes pre IDT. No GDR." Review of the BMMRs since 03/20/12 revealed there were no documented behaviors of tearfulness.</p> <p>In an interview on 07/12/13 at 11:13 am. Staff F said "we did do a GDR to a point, but then the daughter refused to have it any lower. Social Services is aware and has addressed all that."</p> | F 329 | <p>RECEIVED AUG 17 2013 D6851AC5848</p> |

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| F 329 | Continued From page 49 In an interview on 07/16/13 at 8:31 a.m. Staff N indicated the resident was on [REDACTED] for tearfulness, which was well managed and the resident continued on [REDACTED] to prevent reoccurrence of tearfulness. He also stated the resident's daughter refused a GDR. Staff N confirmed the last attempted GDR was in 2011. Failure to pursue a gradual dose reduction in light of no signs or symptoms of [REDACTED], without a medical contraindication, constitutes the use of an unnecessary drug. | F 329 | | | |
| F 406 SS=D | 483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to provide services identified in the Level II Preadmission Screening and Resident Review (PASRR) assessment for one of one (#80) residents reviewed for Level II PASSR services of the 25 residents who were included in the Stage 2 revew. This failure placed the resident at risk for | F 406 | F 406 PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES <u>Plan of Correction</u> 1. Resident #80 Care Plan has been reviewed and updated to reflect PASRR Level II Psychiatric Evaluation recommended strategies that remain appropriate for resident. Resident #80 has been referred to Mental Health Services Resident #80 Behavior Monitor Flow Sheet has been documented and implemented. 2. Levell II PASRR evaluations have been reviewed by Social Services for recommended strategies and further need of evaluations. Care Plans and behavior monitor flow sheets have been updated as needed & Mental Health referrals made as needed. | 8/22/13 | |

9
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| F 406 | <p>Continued From page 50 untreated mental health disorders.</p> <p>Findings include:</p> <p>RESIDENT #80 In an interview on 07/09/13 at 1:00 p.m., Resident #80 was noted to be anxious about an upcoming room change. She did, however, state she was told there were more activities and people she might be able to communicate with on the floor to which she was moving, and that seemed to please her.</p> <p>According to the 04/05/13 admission Minimum Data Set (MDS), Resident #80 admitted to the facility with diagnoses of [REDACTED] and [REDACTED]. This MDS assessed the resident received an [REDACTED] medication daily. Review of Physician's orders revealed the resident also received as needed doses of [REDACTED] for [REDACTED] and [REDACTED] for [REDACTED].</p> <p>A Level II Psychiatric Evaluation was conducted on 03/27/13, while the resident was in the hospital prior to her admission to the facility, due to the resident's history of [REDACTED] and recent "increased symptoms of [REDACTED]". The Evaluation identified the resident required mental health services to include: [REDACTED] medication evaluation / management" to monitor the efficacy of [REDACTED] medications, and "individual / group therapy". In addition, recommended strategies to promote successful placement included direction to staff that the resident did not pick up on subtle humor and "make sure she understands if staff is kidding" as it "may cause her undo distress and increase her [REDACTED]". It was also noted the resident should be assisted to "connect with other residents who are cognitively</p> | F 406 | <p>3. Social Services staff have been re-educated by the Executive Director on reviewing Level II PASRR evaluations of residents, implementing and documenting in residents medical records recommended strategies if appropriate, and Mental Health referral procedures.</p> <p>Psychotropic Committee will review newly admitted resident PASRR evaluation the month of admission and quarterly thereafter to ensure necessary documentation and recommendations are present in the resident plan of care and medical record and that Mental Health referrals have been made if needed. Any findings will be forwarded to the Executive Director.</p> <p>4. Quality Assurance Committee will ensure compliance.</p> <p style="text-align: right;">8/22/13</p> |

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| NAME OF PROVIDER OR SUPPLIER SEATTLE MEDICAL POST ACUTE CARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 555 16TH AVENUE SEATTLE, WA 98122 | | |
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| F 406 | <p>Continued From page 51</p> <p>intact" and that she "may be interested in teaching games to others". It was also recommended that the facility "monitor for any increases in her [REDACTED] as evidenced by changes in her appetite, sleep, concentration level, participation level and overall mood presentation". Additional needs identified included continued respiratory therapy consults, as well as occupational and physical therapy and mental health counseling.</p> <p>A specific recommendation was included for mental health services as the resident "has expressed a strong interest in having MH (mental health) counseling to address stressors. Help her to connect with a provider while in the (nursing facility)".</p> <p>Review of the resident's comprehensive care plan revealed the recommendations made by the Level II Evaluation were not included. In addition, there was no behavior monitoring in place related to the resident's [REDACTED] or [REDACTED]. There was no indication in the resident's record that she had been referred to, or seen by mental health, nor that it had been addressed with her.</p> <p>In an interview on 07/16/13 at 8:31 a.m., Staff N, Social Services Director, stated he was not aware the resident had a Level II evaluation. He acknowledged the resident did not have a care plan that addressed either her [REDACTED] or [REDACTED], nor one that addressed the recommendations made in the Level II evaluation. He also stated behavior monitoring should have been in place, however it was not. He stated mental health services had not been offered or provided. He was unable to explain why none of the Level II recommendations had been followed</p> | F 406 | | |

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| F 425 | Continued From page 53 determined the facility failed to: clarify Physician's Orders; ensure medications were administered as ordered; and follow current standards of practice regarding the administration of medications for seven (#s 74, 86, 49, 26, 21, 76 & 71) residents of the 25 residents who were included in the Stage 2 review. Failure to ensure staff administered all narcotic, insulin, anti-depressant and bowel medications according to physician's orders to meet the needs of each resident placed residents at risk for constipation, sedation and low blood sugars. In addition, these failures placed residents at risk for untreated medical conditions and medication errors. Findings include: Refer to CFR 483.25(l), F-329, Unnecessary Drugs RESIDENT #74 Review of medication pass on 07/15/13 revealed the resident had a Physician's Order (PO) for the narcotic [REDACTED], once a day as needed for [REDACTED]. Review of Medication Administration Records (MARs) and narcotic disposition records revealed that staff administered the [REDACTED] more than once a day on 11 occasions: July 1, 3, 5, 6, 8 and 9/13 as well as June 14, 17, 18, 19 and 21/2013. In an interview on 07/11/13 at 1:53 p.m. Staff B (Director of Nursing) could not explain why the process to administer medication for this resident wasn't followed. Staff B stated, "I expect nurses to follow orders...". RESIDENT #86 According to Resident #86's February 2013 MARs, the physician ordered a taper of the | F 425 | 3. Resident Care Mangers will review physician orders to the Medication Administration Records monthly to ensure that medications are being administered as ordered. Any review findings will be forwarded to the Director of Nursing. 4. Quality Assurance Committee will ensure compliance. | 8/22/13 | |

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| F 425 | <p>Continued From page 54</p> <p>██████████ From 02/01-05/13, staff were to administer 37.5 milligrams of the medication each day, however the MAR was blank, indicating the resident did not receive the medication that was ordered.</p> <p>In an interview on 07/15/13, Staff D (Medical Records) confirmed there was no indication the resident received the medication. Facility staff failed to administer medications to meet the assessed needs of Resident #86.</p> <p>RESIDENT #49 Resident #49 was admitted to the facility with a diagnosis of ██████████ and ██████████ issues.</p> <p>Review of POs revealed directions to staff to assess blood sugars and administer insulin based on those results three times a day and ██████████ (insulin) for (blood sugars) less than 100." Review of MARs revealed nursing staff administered insulin for blood sugars less than 100 (outside physician ordered parameters) on eight occasions: 05/03, 20, 24 and 26/13; and 06/15, 18, 21, and 29/13.</p> <p>Additionally, July 2013 MARs revealed staff did not administer seven of 10 morning doses of long acting ██████████ and five of 10 short acting ██████████ doses to Resident #49.</p> <p>In an interview on 07/10/13 at 10:26 a.m., Staff F (Resident Care Manager, responsible for the coordination of the resident's care) indicated he was not aware the resident had not recieved multiple insulins in July. Staff F indicated the physician should have been notified the resident didn't receive the ordered medication and that he</p> | F 425 | | |
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| F 425 | <p>Continued From page 55 (Staff F, the RCM) should have been notified.</p> <p>In an interview on 07/11/13 at 1:53 p.m. Staff B stated, "I expect nurses to follow orders...". Staff B further indicated if staff do not follow POs, they are to notify the primary physician. Failure of facility staff to administer medications as directed, or notify the physician medications were not administered, had the potential to cause Resident #49 fluctuating blood sugars.</p> <p>RESIDENT #26 Physician's orders, dated 01/24/13, directed staff to administer five units of Regular Insulin when the resident's [REDACTED] was "greater than 300". The order also indicated "Do not give more frequently than" every six hours. Staff were also directed to check the resident's CBG before each meal, with a PO dated 01/24/13.</p> <p>Review of the MAR revealed staff checked the resident's CBG prior to each meal daily. On numerous occasions, the resident was noted with a CBG greater than 300, and staff administered the insulin. The resident was then noted, on 11 occasions including 07/05, 06, 07 and 08/13, with a CBG greater than 300 at consecutive meals. As the meals were less than six hours apart, however, staff did not administer insulin.</p> <p>Physician's orders also directed staff to notify the physician if the CBG was less than 60 or greater than 400 before meals. While the resident was noted with a CBG greater than 400 on 26 occasions in May, June and July, 2013. there was no indication the physician was notified of any of the occurrences.</p> | F 425 | |

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F 425

Continued From page 56

In an interview on 07/15/13 at 11:30 a.m., Staff G was unable to find any indication the physician was notified each time the blood sugar was higher than 400. She stated an ARNP was in the building almost daily and was likely told at the time the CBG was checked. However, Staff G then noted a majority of the occasions when the CBG was greater than 400 occurred at the 5:00 p.m. check. She stated, "Well, they aren't here then. We would have had to call or fax." She acknowledged it did not appear staff followed the PO. Staff G also stated the PO that directed staff to administer insulin six hours apart should have been clarified since there were less than six hours between meals. "I don't know why we would check the glucose but then not treat if over 300. We should have clarified that."

RESIDENT #21
According to the Nutrition Care Area Assessment written after completion of the 05/13/13 MDS, Resident #21 was assessed "at high risk of metabolic abnormalities secondary to her medications and [REDACTED] conditions... she has been relatively stable since here. Her lab values will be observed and reported to her physician as ordered."

The 05/13/13 Hyperglycemia/hypoglycemia Care Plan instructed staff to "monitor for s/s (signs/symptoms) of unstable blood sugar", "perform accuchecks as ordered" and "report to physician s/s unstable bs (blood sugar)"

Review of PO revealed a 06/12/13 order for NPH insulin two times daily and "notify MD if CBG (Capillary Blood Glucose) is less than 60 or greater than 400".

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| F 425 | <p>Continued From page 57</p> <p>Review of the June 2013 MAR revealed a CBG result on 06/02/13 at 8:00 a.m. of 425, on 06/09/13 at 8:00 a.m. a CBG result of 432 was documented, and on 05/02/13 at 8:00 p.m. the CBG was 404. Record review revealed no indication the physician was notified on any of the above occasions as ordered.</p> <p>In an interview on 07/12/13 at 10:50 a.m. Staff F said, "In her case the upper parameter was removed." In an interview on 07/16/13 at 11:15 a.m. Staff B said the physician should be notified "according to parameters" and in the event there were no parameters, then the physician should be notified for CBG "greater than 400."</p> <p>RESIDENT #76 On 07/09/13 at 12:41 p.m. during medication administration observation Staff S was observed to administer five units of insulin into Resident #76's left outer upper arm, at a 90 degree angle. Staff S did not pinch the surrounding skin. According to 2014 Nursing Drug Handbook "Drug is usually given subcutaneously. To give, pinch a fold of skin with fingers at least 3 inches (7.5 cm) apart and insert needle at a 45-90 degree angle. In an interview on 07/09/13 at 1:25 p.m. Staff S said "I should have pinched." Staff S failed to follow nursing standards when administering a medication.</p> <p>RESIDENT #71 According to the Admission MDS Care Area Assessment, Resident #71 was at "high risk of constipation related to his... diagnosis. He was constipated which was relieved on May 23...".</p> <p>Review of POs revealed from 05/21/13 through 06/26/13 Resident #71 was to receive a daily</p> | F 425 | | |

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| F 425 | <p>Continued From page 58</p> <p>██████████ which staff noted was administered. In addition, the resident had POs to receive MOM if no BM for two days and a ██████████ on day 3 if MOM was not effective.</p> <p>Review of the 06/13 Bowel Monitor Flowsheet revealed the resident went 12 shifts, from 06/05 through 06/09/13 without a BM and without staff following the POs for administration of MOM.</p> <p>In an interview on 07/12/13 at 7:02 a.m., Staff H, Licensed Nurse, stated "the way the orders read, we're giving the ██████████ daily. Then if no BM in 2 days, give MOM. If still no BM, I would call the doctor before giving another ██████████, since he was getting one routine and see if she wanted us to still follow the protocol or go to an enema." Staff Crystal acknowledged it did not appear POs were followed 06/05 through 09/13. She also stated staff should have clarified the POs while the resident received the routine ██████████.</p> | F 425 | <p>F 431 DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p><u>Plan of Correction</u></p> <p>1. Expired medication found in the first floor medication room has been discarded appropriately.</p> <p>Insulin for Resident #79 and #28 has been discarded and replaced with new insulin medication which have been dated according to guidelines</p> <p>Eye drop medications have been discarded and replacement medications have been dated according to guidelines.</p> | 8/22/13 |
| F 431 SS=D | <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the</p> | F 431 | | |

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| F 431 | <p>Continued From page 59</p> <p>appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure medications were labeled, stored, dated and discarded according to facility policy and pharmacy standards. Failure to label, store, date and discard medications as indicated, on one of three floors, one of five medication carts, and for three (#s 33, 86 & 122) of four resident observed with medications at bedside of the 35 residents who were included in the Stage 1 review, placed residents at risk to receive medications that were expired and placed residents at risk for accidental ingestion of medication for which they were not intended.</p> | F 431 | <p>Expired medication, Enoxaparin has been discarded.</p> <p>Injectable lidocaine has been dated according to regulations.</p> <p>Resident #33 bedside has been cleaned of any medication.</p> <p>Resident #122 has been discharged from the facility.</p> <p>2. Facilities medication rooms and medication carts have been reviewed by the Director of Nursing and or designee to ensure that medications are dated properly and no outdated medications are present. Any findings were corrected immediately.</p> <p>Resident bed stands have been reviewed for presence of any medications. Any findings were corrected immediately.</p> <p>Resident "self-medication" programs were reviewed for all appropriate medication storage. Any findings were corrected immediately.</p> <p>Licensed Staff have been re-educated on pharmacy standards and facility policy of medication labeling, storage, dating and discarding process, including the system to account for the receipt,</p> | 8/22/13 | |

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| F 431 | <p>Continued From page 60</p> <p>Additionally, the facility failed to ensure a system by which staff could accurately reconcile controlled substances for one (#74) of three residents who received a narcotic during medication pass observation of the 14 residents observed for medication pass, which placed residents at risk for misappropriated and diverted controlled substances and detracted from staff's ability to assess resident pain medication use.</p> <p>Findings include: Refer to CFR 483.60(a), F-425, Pharmacy Services</p> <p>MEDICATION ROOM Observation during initial rounds on the morning of 07/08/13 of the 1st floor medication room with Staff M, licensed nurse, revealed two opened [redacted] discus for Resident #5 with a manufacturer's expiration date of 06/13. Staff M stated the resident usually kept the Advair at his bedside and she was "not sure why they're in here". She stated as they were expired they should have been in the discard bin.</p> <p>MEDICATION CART Observation during initial rounds on the morning of 07/08/13 on the second floor revealed the following:</p> <p>Medication cart #2 contained insulin for Resident #79 which was dated 06/05/13 and insulin for Resident #28 dated 05/11/13. Two eye drop medications were noted to be opened but not dated. In an interview on 07/08/13 at 10:20 a.m. Staff S stated, "the insulin is good for 28 days and should be discarded." Staff S also indicated all eye drops should be dated when opened. Also identified on the medication cart was one expired</p> | F 431 | <p>usage, disposition and reconciliation of all controlled substances.</p> <p>4. Director or Nursing and or designee will perform random audits for 3 months to ensure that medications are being labeled, stored, dated and discarded according to facility policy and pharmacy standards. Audit findings will be forwarded to the Executive Director.</p> <p>Quality Assurance will ensure compliance.</p> | 8/22/13 |
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| F 431 | Continued From page 61 enoxaparin (a medication to prevent blood clots) injection. Medication cart #1 contained: a cup with three syringes that were coated with a pink fuzzy substance. Staff stated "we don't use that anymore" and discarded the syringes. A vial and a pen insulin which were opened and not dated for a resident who had discharged and two bottles of eye drops and one bottle of ear drops which were opened and not dated. Polysporin antibiotic powder, with a manufacturer expiration date of 03/2010 was also identified. Staff stated, "we don't use that" and discarded the antibiotic powder. A vial of injectable lidocaine was opened and not dated. According to the Licensed Nurse, "we're suppose to date it." Failure to date medications when opened placed residents at risk to receive expired medications. Failure to dispose of medications that were clearly expired placed residents at risk to not receive the full intended effects of the medications. MEDICATION STORAGE 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. In addition, the facility should have procedures for the control and safe storage of medications for those residents who can self-administer medications. RESIDENT #33 Observations on 07/09, 10, 11, 12/13 revealed the presence of multiple [REDACTED] at Resident #33's bedside. In an interview on 07/12/13 at 8:33 a.m., Staff R, Nurse Consultant, confirmed the presence of [REDACTED] at the | F 431 | | |
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| F 431 | <p>Continued From page 62</p> <p>bedside, stating, "no, medications should not be at bedside unless we have a physicians order..., he does have a lockbox." Record review revealed the resident did not have a physician's order to keep medications at the bedside. Failure to secure medications placed cognitively impaired residents at risk for accidental ingestion.</p> <p>Similar observations were noted on 07/10, 11 and 12/13 for Resident #86, who was noted to have multiple saline syringes at the bedside.</p> <p>RESIDENT #122 Observation of Resident #122's room on 07/08/13 at 9:02 a.m. revealed a bottle of eye drops, two tubes of Bactroban nasal ointment, Arnica montana tablets, a tube of 2% medicated cream and a tube of pain relief cream. All were in sight, not secured and available to other residents.</p> <p>At that time Resident #122 was asked about the numerous medications and treatments at her bedside. She stated she used them all, stating the eye drops she used when she needed them for "dry eye", the Bactroban ointment she used often, the Arnica montana tabs she used "three times a day", the 2% anti itch cream she used "all the time", and the pain relief cream she used on her knee, shoulder and leg for "arthritis pain".</p> <p>Record Review revealed none of the above medications were identified as used by the resident on the 07/13 MAR. The 07/13 Treatment Administration Record (TAR) did include an order for the Bactroban to be used for "seven days post [REDACTED] from 07/02 through 07/08/13, however there was no indication it should be kept at the resident's bedside, nor that the resident was to administer it. None of the other medications were</p> | F 431 | | |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505311 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 07/16/2013 |
| NAME OF PROVIDER OR SUPPLIER SEATTLE MEDICAL POST ACUTE CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 555 16TH AVENUE SEATTLE, WA 98122 | | |
| (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 431 | <p>Continued From page 63</p> <p>included on the TAR. In addition, there were no POs for the eye drops, pain cream, Montana tabs, nor were there any orders for the resident to keep the medications at her bedside or to self administer them.</p> <p>The Self Medication Administration Evaluation was not completed and included only the statement, "7/8/13 Resident is interested in Self med program."</p> <p>In an interview on 07/16/13 at 9:58 a.m., Staff B stated she expected the admitting nurse to review with the resident any medications in their possession, to ensure proper storage and self administration, if applicable. She acknowledged Resident #122 should have a lockbox for the medications and should have been assessed for self administration.</p> <p>RECONCILIATION Regulations require that the facility have a system to account for the receipt, usage, disposition, and reconciliation of all controlled medications. This system includes, but is not limited to: Record of disposition of all controlled medications with sufficient detail to allow reconciliation (e.g., the medication administration record [MAR], proof-of-use sheets, or declining inventory sheets), including destruction, wastage, return to the pharmacy/manufacture, or disposal in accordance with applicable State requirements.</p> <p>RESIDENT #74 According to the Narcotic Disposition Record (NDR) for Resident #74, staff signed out narcotics, but according to the times and dates the narcotics were signed out, they were not administered, according to the MARs.</p> | F 431 | | | |

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505311 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 07/16/2013 |
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| F 431 | <p>Continued From page 64</p> <p>For example, NDRs indicated staff dispensed [REDACTED] 5 milligrams (mgs) for Resident #74 on 06/07, 08, 15/13 but there was no indication on the MAR the resident received these medications.</p> <p>Review of NDRs for June 2013 revealed staff dispensed a total of 27 [REDACTED] for Resident #74. Review of the front of June MARs revealed the resident received 15 doses of [REDACTED] and the back of June MARs revealed the resident received 18 doses of [REDACTED], leaving staff unable to account for nine narcotics. Staff failed to ensure a system which accounted for the usage and disposition of controlled medications.</p> <p>Review of July MARs revealed staff dispensed 20 doses of [REDACTED] from 07/01/13 to 07/15/13. The front of the MARs reflected the resident received 15 doses while the back of the MARs reflected the resident received 17 doses of [REDACTED]. In an interview on 07/15/13, Staff G (Resident Care Manager responsible for overseeing the care and services the residents receive) stated, "They should be writing on the front and back of the MAR that the medication is given, and it's effectiveness." Failure to ensure accurate accounting of narcotics placed the resident at risk for misappropriation of medication and rendered the facility unable to account for [REDACTED] thus unable to rule out diversion. Additionally, failure to ensure [REDACTED] records accurately reflected resident use, detracted from staff's ability to determine the use and effectiveness of [REDACTED] medication.</p> | F 431 | | |
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