

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

PRINTED: 11/01/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505504	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/28/2013
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NAME OF PROVIDER OR SUPPLIER COVENANT SHORES HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9107 FORTUNA DRIVE MERCER ISLAND, WA 98040
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(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
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F 000

INITIAL COMMENTS

F 000

This report is the result of an unannounced Quality Indicator Survey conducted at Covenant Shores Health Center on 10/17/13, 10/18/13, 10/21/13, 10/22/13, 10/23/13, 10/24/13, 10/25/13 and 10/25/13. A sample of 25 residents was selected from a census of 41. The sample included 24 current residents and the records of one former and/or discharged residents.

The survey was conducted by:

[REDACTED] BSN, RN
[REDACTED] MN, RN

[REDACTED] MSN, RN
[REDACTED] MS, RD

The survey team is from:

Department of Social & Health Services
Aging & Disability Services Administration
Residential Care Services, District 2, Unit D
20425 72nd Avenue South, Suite 400
Kent, Washington 98031

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Revised 11-1-2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Amela Gil</i>	TITLE <i>Administrator</i>	(X6) DATE 11/14/13
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Residential Care Services	F 000	F278	
F 278	483.20(g) - (j) ASSESSMENT	F 278	<u>How deficiency is corrected:</u>	10/28/13
SS=D	ACCURACY/COORDINATION/CERTIFIED		<ul style="list-style-type: none"> Resident # 37 was re-assessed and correct information was noted on next MDS which was submitted CMS prior to survey. Resident # 69 skin tear related to fall on 7/17/13 was noted on MDS dated 7/19/13, skin tear healed on 8/11/13 therefore skin tear would not be noted on MDS dated 9/15/13. Resident #13 is deceased. 	
	<p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review the facility failed ensure the comprehensive assessments accurately reflected</p>		<p><u>Measures and systems to ensure correction:</u></p> <ul style="list-style-type: none"> MDS nurse attended in-service on CMS website 10/28/13. MDS nurse reviewed Section L & M of RAI manual 10/28/13. <p><u>Quality Assurance Monitoring:</u></p> <ul style="list-style-type: none"> To ensure accuracy, three random audits of MDS assessments will be conducted monthly for three months by the DON or designee. Findings will be reported to QA Committee for recommendation. DON will ensure compliance. 	

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F 278	<p>Continued From page 2</p> <p>the special dietary needs as well as skin and oral status of four of 21 residents reviewed in the investigation portion of the annual survey. Failure by the facility to identify and accurately assess the residents' conditions placed them at risk for unmet care needs.</p> <p>Findings include:</p> <p>RESIDENT #37 Resident 37 was admitted to the facility on [REDACTED] /13 for extensive assistance with activities of daily living and moderate cognition impairment as well as rehabilitative services. The admission comprehensive assessment tool (MDS) dated 8/10/13 noted the resident had no problems related to oral/ dental status.</p> <p>In an interview on 10/18/13 at 9:57 a.m. the resident stated she had four broken teeth. The resident allowed a non invasive visual exam of her smile which confirmed the 4 broken teeth.</p> <p>In an interview on 10/25/13 at 2:00p.m. the Staff C, the MDS coordinator, stated the resident had broken teeth prior to admission to the facility. Staff C stated the teeth had been broken prior to admission. Then Staff C confirmed the admission MDS dated 08/10/13 had incorrect documentation regarding the oral/dental status.</p> <p>RESIDENT #69 Resident #69 was admitted to [REDACTED] 13 for extensive assistance with activities of daily living, multiple medical conditions and rehabilitative services. The resident experience a fall on 07/17/13 which resulted in two skin tears on the [REDACTED] forearm.</p>	F 278		
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F 278	<p>Continued From page 3</p> <p>An observation on 10/22/13 at 10:35 p.m. revealed a scab on the [redacted] forearm with bruise adjacent to the scab. The resident stated the bruise and scab were caused by a fall.</p> <p>Record review of the quarterly comprehensive assessment (MDS) dated 09/15/13 revealed no skin tear noted.</p> <p>RESIDENT #13 Resident #13 was admitted to the facility on [redacted]/2013 after the surgical repair of a hip fracture in an acute care facility. The initial assessment, dated 08/15/2013, identified the resident was at risk for pressure ulcer development. The assessment documented the resident had surgical incisions and required extensive assistance with most activities of daily living; including bed mobility, transfers, grooming, dressing, and hygiene. An additional assessment dated 8/22/2013 documented the resident had no pressure ulcers or skin impairments other than the surgical wounds that were identified on 08/15/13</p> <p>A progress note entry by the Primary Care Physician (PCP) dated 09/24/2013, noted the resident had developed pressure sores related to a splint/ leg immobilizer that was being used to treat the hip fracture.</p> <p>On 09/19/13 was an unscheduled assessment documented the resident had two venous ulcers. Even though the PCP identified the pressure sore(s) were related to use of the splint on 09/24/2013, a correction of the assessment was not completed. The section of the assessment tool intend to identify pressure sores documented the resident had no pressure ulcers. Not accurately</p>	F 278		
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F 278	Continued From page 4 documenting the pressure sores left the facility staff without needed information to implement care plan interventions to assist with wound healing.	F 278	F280 <u>How deficiency is corrected:</u>	11/26/13
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to review and revise care plans for Resident #68, 17, 50, 30, 13 and 57, six of 21 sampled residents, to reflect their current care needs. Failure to revise and update care plans placed residents at potential risk for unmet	F 280	<ul style="list-style-type: none"> ▪ Resident #13 is deceased. ▪ Resident # 17, 50, 30, 13, and 57 care plans have been reviewed, revised, and updated by RN (11/11/13) with input from resident/responsible party and IDT. ▪ Resident # 68 care plan revised and updated by RN (11/11/13). Significant weight loss communicated to staff and physician. Interventions put in place to prevent further weight loss are stated in revised care plan. ▪ Resident #69 care plan updated to reflect skin tear on 7/17/13. Skin tear was healed on 8/11/13 therefore would not be noted on MDS dated 9/15/13. Skin tear was noted on MDS dated 7/19/13. <u>Measures and systems to ensure correction:</u> <ul style="list-style-type: none"> ▪ All LN staff to attend in-serviced on updating and revising care plans by 11/12/13. ▪ All resident care plans will be reviewed to ensure all care plans are accurate, up to date with interventions reflecting residents 	

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F 280 Continued From page 5
needs, care and services.

Findings include:

RESIDENT #13

Resident #13 was admitted to the facility on 8/13 after the surgical repair of a hip fracture in an acute care facility. The initial assessment, dated 08/15/2013, identified the resident was at risk for pressure ulcer development and noted the resident was extensive assistance with most activities of daily living including bed mobility, transfers, grooming dressing and hygiene.

On 09/19/13 was an unscheduled assessment documented the resident had two venous ulcers. However on 09/24/13 the physician assessment of the wound documented the wound was a " pressure sore from splint."

Review of the facility care plan found it noted it had been in effect since 08/08/13, the date of admission. Although the problem area noted the resident had vascular insufficiency in the right lower leg and skin breakdown related to poor circulation. The diagnosis and problem did not exist at the time of admission.

The resident was observed with an alternating air pressure mattress; however review of the clinical record did not reveal how long the device had been in place. In addition, since the resident's initial admission the resident was hospitalized. The resident was readmitted to the facility on 9/29/13. On 10/3/13 the initial assessment for hospice services was completed and the resident was placed on the service for end of life treatment.

F 280 Quality Assurance Monitoring:

- LN will review care plans daily for a week for all residents on alert as assigned. All resident care needs requiring interventions are addressed, documented, current and accurately reflects the resident's care.
- Director of Nursing or designee will review a 10% random sample of care plans one time a week for one month and every other week for one month to ensure the review and revision of care plans.
- Results will be reviewed with QA Committee.

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F 280	<p>Continued From page 6</p> <p>The initial assessment completed by the hospice Nurse noted the resident ability to participate in the activities of daily living had declined. Although the decline in the resident condition and ability to participate in activities of daily living was noted by the Hospice Nurse, the care plan directives for staff had not been updated.</p> <p>The only directives updated on the care plan after the return to the facility included the additional of hospice services (dated 10/4/13), the initiation of a restorative nursing program (dated 10/04/13) and the use of oxygen and monitoring the resident oxygen saturation level (dated 9/30/13).</p> <p>There was no updated information to describe what assistance was now needed with activities of daily living. The treatment sheet showed noted the splint was not used after 09/18/13, but the nursing progress notes repeatedly referred to the presence of a splint on the right leg after it was discontinued.</p> <p>On 10/25/13 at 2:00 p.m., Staff B was interviewed about the residents care plan. She stated she did not know how long the alternating air pressure mattress had been used. During a follow up interview on 10/28/13 Staff B was asked again but could not provide any additional information to document when the specialty mattress was implemented.</p> <p>The care plan dated 8/8/13 found the resident was identified at risk for skin breakdown. The interventions included use a skin barrier and monitoring the resident for incontinence, monitoring the skin and reporting changes, use of pillows, pads or wedges to reduce pressure on heels and pressure points. A directive noted skin</p>	F 280		
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F 280	<p>Continued From page 7 checks would be completed once a week starting 08/16/13.</p> <p>The care plan did not include any information to indicate the leg splint present on admission was discontinued or note the date in the change in the care plan. In addition the care plan did not identify the alternating air pressure mattress or the date the intervention was implemented, nor did it indicate if the resident needed repositioning while in bed.</p> <p>Although the treatment sheet showed noted the splint was not used after 09/18/13, the nursing progress notes repeatedly referred to the presence of a splint on the right leg even after it was discontinued.</p> <p>Not ensuring the care plan accurately identified the interventions implemented to minimize the risk of the development of additional wounds and identify the date they were implemented left the facility staff without information needed to evaluate the efficacy of the care plan interventions and the need to implement changes in care.</p> <p>RESIDENT # 68 Resident # 68 was admitted on [REDACTED] 13 at 161 pounds and was 61 inches tall, without a recent weight loss. Her initial assessments for nutrition and potential for weight loss were adequate to protect her. She had no chewing or swallowing problems, and no therapeutic or mechanically altered diet.</p> <p>Resident # 68 had a significant weight loss in 180 days, was 161 pounds on 4/22/13 and was 136 pounds on 10/17/13. The registered dietician reassessment done on 10/10/13 identified a 13%</p>	F 280		
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F 280	<p>Continued From page 8</p> <p>weight loss in 180 days, which was a significant loss. The dietician liberalized Resident # 68's diet, did not add a supplement, and discussed her laboratory results, and deemed her a medium risk nutritionally.</p> <p>In an interview the with the dietician on 10/24/13 at 7:40 a. m., she explained that, "Nurses are informed of weight loss by the weekly meetings, the director of nursing services attends and informs the licensed nurses."</p> <p>The care plan goal of body weight of 142 pounds plus or minus 3 pounds addressed weights, laboratory results, her food and fluid intake, dehydration, nutrition, and diet texture. The care plan on 10/24/13 contained nothing about her significant weight loss in 180 days.</p> <p>Two of her direct care staff were interviewed, Staff G on 10/24/13 at 7:20 a. m. and Staff H on 10/24/13 at 8:00 a. m. about Resident # 68's weight loss. Staff H said, "She is losing weight but not too much." Both care staff did not know she had a significant weight loss in October, and did not know she was underweight.</p> <p>Resident # 68 lost a significant amount of weight, is now nine pounds under her planned weight, her diet was liberalized and she was eating as much as she wants. The care plan did not reflect analysis or planning for her significant weight loss in 180 days, nine pounds under goal without alert that she is under and still losing.</p> <p>On 10/25/13 at 11:00 a. m. Staff B stated the change of the resident's condition should have been addressed on the care plan. RESIDENT #30</p>	F 280		

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F 280	<p>Continued From page 9</p> <p>Resident #30 was a long-term resident with the most recent admission dated [REDACTED]/13. The resident had multiple medical conditions which required feeding via a gastrostomy tube (G-tube) and extensive care assistance with activities of daily living.</p> <p>An observation on 10/20/13 at 4:55 p.m. revealed the resident oversalivated during the infusion of the G-tube feeding and exhibited dry circular patches on his lips. The resident stated the staff was supposed to get salve to put on his lips but had not that day. This intervention was not found on the care plan.</p> <p>An observation on 10/22/13 at 1:53 p.m. the revealed the resident oversalivating during the infusion of tube feeding. The lower lip of the resident had fresh pink skin exposed and peeled skin attached to the corner of his mouth. The resident stated the staff had not provided the lip salve but would soon.</p> <p>In an interview on 10/25/13 at 11:30 a.m. Resident #30 stated the staff had not provided lip protection/salve.</p> <p>In an interview on 10/25/13 at 2:15 p.m. Staff C confirmed lip protection/salve was available as a floor stock supply item which nurses could provide residents. He recalled this resident had received it in the past. Staff C confirmed there was no notation in the treatment orders, nursing care plan or nursing aides' care directives this was to be provided to the resident.</p> <p>RESIDENT #57 Resident #57 had resided in the facility mutiple</p>	F 280		

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F 280	<p>Continued From page 10</p> <p>years with declining health related to mutiple medical conditions and dementia.The resident currently required total assistance for activities of daily living which included transfers in and out of bed with a mechanical lift.</p> <p>Record review of the nursing care plan noted effective from 04/18/13 to present identified the resident capable of toileting and used the call bed for assistance. The nursing aides' care directed noted the resident had ambulating ability with an unsteady gait and a mechanical lift was to be used when the resident was tired or sleepy.</p> <p>Record review of progress notes dated 10/20/13 at 10:51a.m. Staff K, the licensed nurse documented Resident #57 was not able to make his needs known.</p> <p>On 10/23/13 at 9:53 a.m. Staff B, the DNS, stated Resident #57 level of functioning has declined and he no longer toileted in the bathroom, ambulated or called for assistance. Staff B confirmed the care plan had not been revised to reflect that change.</p> <p>RESIDENT #69 Resident #69 was admitted to the facility on [REDACTED]/13 for multiple medical conditions and rehabilitative services. The resident was assessed to be cognitvely intact but due to an unsteady gait experienced a fall on 07/17/13 and incurred two skin tears on her right forearm.</p> <p>An observation on 10/22/13 at 1:35 p.m. revealed a bruise adjacent to a scab on the resident's right arm. Resident #69 stated this occurred when she fell in July. The resident also stated, "It has taken</p>	F 280		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505504	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/28/2013
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NAME OF PROVIDER OR SUPPLIER COVENANT SHORES HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9107 FORTUNA DRIVE MERCER ISLAND, WA 98040
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F 280	<p>Continued From page 11 forever to heal."</p> <p>Review of the fall investigation dated 07/18/13 revealed first aid was provided for the resident and the nurse initiated a treatment order to clean and monitor until healed. In the follow up report of the investigation there was a negative response to "care plan updated."</p> <p>Review of the nursing progress notes addressed the condition of the steri strips and no assessment of the wounds on 07/18 to 25/13. No further documentation was found.</p> <p>Review of the weekly skin assessment documented on the Medication Administration Record (MAR) revealed no issues noted.</p> <p>In an interview 10/25/13 at 11:06 a.m. Staff B, the DNS, stated with a skin issue the nurse initiated a skin investigation flowsheet, initiated a treatment and documented in the progress notes and weekly skin assessment. Staff B stated the nursing care plan should have addressed the skin tears Resident #69 incurred with her fall. RESIDENT #17 Resident #17 was admitted to the facility 03/14/12 with care needs related to dementia. According to the 08/18/13 quarterly MDS this resident needed extensive assistance with most activities of daily living (ADLs) to include dressing. Resident #17 was not ambulatory.</p> <p>On 10/23/13 at 9:19 a.m. Resident #17 was observed coming down the Rose hallway in her wheelchair. Resident #17 was self-propelling with her left foot which had a sock on it. Staff I asked Resident #17 why she didn't have her shoe on. Resident #17 stated that she didn't have it on</p>	F 280		
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F 280	<p>Continued From page 12</p> <p>because her left foot was hurting. Staff I assessed the area of pain and found a scab to the left fifth toe area that measures 0.2cm x0.2 cm. At 10:03 a.m. Staff I was observed putting in treatment orders to cleanse and monitor the scab, however, there was no update done to the resident's care plan.</p> <p>On 10/24/13 at 9:12 a.m. Resident #17 reported her left toe felt better, but voiced that her left heel was having pain. On 10/24/13 at 1:44 p.m. Resident #17 had a splint on her left foot/heel while in her wheelchair. On 10/25/13 at 9:00 a.m. and 1:26 p.m. Resident #17 was again observed with a splint on her left foot/heel while in her wheelchair. However, review of the ADL care plan under dressing revealed staff were directed to apply a left heel splint while the resident was in bed. The care plan did not address the resident wearing the splint while not in bed.</p> <p>On 10/25/13 at 1:50 p.m. Staff I was asked if the resident was wearing the same splint she was to wear while in bed. Staff I stated it was the same splint and indicated she was wearing it (while out of bed) due to her report of heel pain.</p> <p>On 10/25/13 at 2:40 p.m. Staff C confirmed the care plan was not updated to include use of the splint during the day along with the goals or outcomes expected from it's use.</p> <p>RESIDENT #50 Resident #50 was admitted to the facility [REDACTED]/12 with care needs related to Alzheimer's, difficulty in walking and muscle weakness. According to the 08/29/13 quarterly MDS Resident #50 needed extensive assistance with all ADLs to include toileting which was listed to require "Two+</p>	F 280		
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F 280

Continued From page 13 persons physical assistance."

Review of the care plan listed interventions such as reminding the resident "to call for assistance before getting out of bed to walk" or to remind the resident "to call for assistance before going to the toilet." Another intervention directed staff to "supervise ambulation to prevent falls or other injuries..."

During an observation 10/22/13 at 1:57 p.m. Resident #50 was laying in bed and did not respond appropriately when asked questions. The call light was in reach, however the resident could not demostate how to use it when prompted. Similar observations were made 10/24/13 and 10/25/13 both at 9:00 a.m. Resident #50 was observed laying in bed. At no point was the resident observed trying to get up to ambulate and was never observed asking staff for help in any way, although the care plan suggested the resident had these capabilities.

On 10/25/13 at 1:29 p.m. Staff I (Licensed Nurse) stated "Her dementia is advanced so she is really confused. She can't call for help..."

On 10/28/13 at 8:30 a.m. Staff G (Certified Nursing Assistant) stated Resident #50 was not able to call for assistance or ambulate on her own.

On 10/28/13 at 8:58 a.m. Staff B stated "no she can't walk" and indicated the care plan should have been updated.

F 280

F 282
SS=E

483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

F 282

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F 282

Continued From page 14

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observations, interview and record review the facility failed to have a system in place that linked care directives with care plans to implement the care and services for four of 21 residents (#57, 61, 30 and 50). This failure placed residents at risk for inadequate and insufficient care and services.

Findings include:

RESIDENT #57
Resident #57 has resided in the facility over 2 years. The care needs of the resident have increased to total dependence on facility staff to provide all grooming and oral hygiene needs. The resident latest quarterly assessment (MDS) dated 09/30/13 identified the resident held food in his mouth and possibly had residual food in his mouth after meals.

On 10/24/13 at 10:30 a.m. record review of the Nursing Care Report with an effective date of 04/18/13 to present revealed oral care was to be provided after each meal and at bedtime. Interventions aspiration precautions and keep secretions clear from mouth and throat.

An observation on 10/22/13 at 9:03 a.m. revealed Resident # 57 smiled and displayed food debris across his upper and lower teeth.

F 282

F282

How deficiency is corrected:

- Resident # 57, 50, 30, and 61, care plans have been reviewed, revised, and updated by RN (11/11/13) with input from resident/responsible party and IDT.
- Resident # 57 and #61 nursing staff re-educated on oral care implementation and frequency (11/13/13). Return demonstration completed.
- Resident # 30 was assessed and lip balm provided per treatment plan. Resident has lip balm at bedside and able to self apply.
- Nursing staff re-educated (by RN 11/13/13) regarding need to follow care plan and provide care.

11/15/13

Measures and systems to ensure correction:

- All interdisciplinary care plan team members responsible for writing and implementing care plans will be re-educated on procedure for developing Comprehensive Care Plan as well as updating and reviewing by RN 11/15/13.
- All nurse assistances will be in-serviced on the importance of

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F 282	<p>Continued From page 15</p> <p>An observation on 10/23/13 at 1:41 p.m. revealed Resident #57 smiled and displayed food debris in this teeth. At 1:48 p.m., Staff Q and Staff R placed the resident in bed for an afternoon rest. No assessment of the mouth or oral care was observed.</p> <p>An interview on 10/23/13 at 9:55 a.m. with Staff Q, nursing aide, revealed oral care is provided before breakfast most days for Resident #57. Staff Q stated the resident occasionally received oral care after breakfast because he was too sleepy before the meal. Staff Q also stated the Accunurse program directed nursing aide care through an audible headpiece system notified aides to provide oral care with AM care and PM care.</p> <p>On 10/25/13 at 3:00 p.m. record review of the Accunurse program ADL Plan of Care confirmed the statement of Staff Q regarding oral care to be done in morning and evening with no reference to after meal time.</p> <p>In an interview on 10/25/13 at 2:15 p.m., Staff C, MDS coordinator, confirmed the discrepancy between the Accunurse program and the nursing care plan. He was unable to identify which care plan was to be implemented for Resident #57.</p> <p>In an interview on 10/28/13 at 9:15 a.m. Staff B, the DNS, confirmed the nursing care plan intervention of oral care after each meal and before bedtime was correct. Staff B stated revision of the Accunurse directives are completed with care plan revision by the floor licensed nurse or Staff C. Staff B confirmed the discrepancy between the Accunurse directives</p>	F 282	<p>following care plan directives (by 11/15/13) and return demonstration for nursing care skills.</p> <ul style="list-style-type: none"> * LN will update care plan and nurse assistant directive concurrently. <p><u>Quality Assurance Monitoring:</u></p> <ul style="list-style-type: none"> * Care plans will be reviewed weekly in accordance with care plan review schedule by MDS nurse. All care plans will be updated as indicated. The Director of Nursing, or designee, will complete random weekly audits of care plan for six weeks. Random audits will be completed to ensure that comprehensive care plans are developed for residents. Audits will be reviewed with QA Committee. * Random audits of one nurse assistant per unit per shift following care directives will be performed twice a week for one month, then weekly for two month. 	

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F 282 Continued From page 16 and the Nursing Care Plan then stated, "This needs to be fixed."

RESIDENT #61
Resident #61 has resided in the facility since [REDACTED] 11. The quarterly comprehensive assessment (MDS) dated 3/01/13 assessed the resident to be cognitively intact. A decline was noted in most recent MDS dated 08/09/13 which identified the resident as severe cognitive impairment. The assessment also identified extensive assistance needed with personal hygiene.

On 10/24/13 at 10:00 a.m. a record review the of the Nursing Care Plan dated 12/07/12 to present revealed oral hygiene was to be done 4 times daily by the nursing assistants. The Accunurse program instructed the nursing assistants to monitor tooth care once on day shift and once on evening shift as well as dip the toothbrush into a Peridex solution.

In an interview on 10/24/13 at 10:10 a.m. Staff R stated she provided a set up for oral care and the resident did it herself. Staff R stated the LN provided a mouth wash for the resident after breakfast.

In an interview on 10/25/13 at 8:35 a.m. Staff R stated the resident cleaned her teeth before breakfast. Observation of the toothbrush revealed multiple specks of green and brown food debris imbedded in the toothbrush. Staff R was unable to explain why the food debris remained in the toothbrush when she had assisted the resident.

In an interview on 10/28/13 at 9:15 a.m. Staff B stated she was not aware of the discrepancy

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F 282	<p>Continued From page 17</p> <p>between the Accunurse directives and the nursing care plan. Staff B stated the supervision of the nursing assistants by the licensed nurses occurred at the beginning and end of each shift. The facility currently lacked a staff development personnel who would evaluate the care provided by the nursing staff on a regular basis.</p> <p>RESIDENT #30 Resident #30 was a long-term resident with the most recent admission dated [REDACTED]/13. The resident had multiple medical conditions which required feeding via a gastrostomy tube (G-tube) and extensive care assistance with activities of daily living.</p> <p>Observations of the Resident #30 on 10/20/13, 10/22/13 and 10/25/13 revealed cracked and peeled skin on his lips with fresh pink skin exposed.</p> <p>Record review of the nursing care plan identified two interventions: monitor skin for redness and oral hygiene and mouth care as needed initiated on 05/16/13.</p> <p>Record review of the nursing progress and weekly skin assessment did not address the condition of his lips.</p> <p>In an interview on 10/25/13 at 2:15 p.m. Staff C stated he remembered this to be a problem for this resident. Staff C recalled giving Resident # 30 lip protection from the floor stock and he was unable to explain how this was overlooked.</p> <p>RESIDENT #50 Resident #50 was admitted to the facility 12/08/12 with care needs related to Alzheimer's and muscle weakness. According to the 08/29/13</p>	F 282		
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F 282	<p>Continued From page 18</p> <p>quarterly Resident #50 needed extensive assistance with most activities of daily living (ADLs) to include bed mobility and transfers.</p> <p>On 10/22/13 at 1:57 p.m. Resident #50 was observed laying in bed on her back. The resident's right foot was in a padded boot and the left heel was in contact with the bed surface, not floated (a pressure relieving technique). On 10/24/13 at 9:35 a.m. Resident #50 was observed again with the heels in contact with the bed surface.</p> <p>Review of care plan revealed Resident #50 was identified to be at risk for pressure ulcers. One of the interventions was to "Use pillows, pads, or wedges to reduce pressure on heels and pressure points." Another part of the care plan entitled "ADL Pan of Care" directed staff to float the heels.</p> <p>On 10/25/13 at 3:05 p.m. Staff C was asked about interventions for Resident #50's pressure ulcer prevention. Staff C stated the resident had a specialized mattress and that the heels were to be floated.</p> <p>On 10/28/13 at 8:46 a.m. Staff G stated that while in bed Resident #50 was to have a "pillow under both legs." On 10/28/13 at 10:40 a.m. Resident #50 was observed in bed with pillows under her legs but the heels were not floated. At this time Staff G was present and acknowledged the heels were not floated and stated "She moves around sometimes." Staff G then readjusted the pillows, however, the heels were still not floated.</p> <p>On 10/28/13 at 11:00 a.m. Staff H was at the bedside of Resident #50. Staff H was asked if the</p>	F 282		
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F 282	<p>Continued From page 19</p> <p>resident's heels were considered to be floated. Staff H stated "No the pillows need to be back more." Staff H then moved the pillows back and was able to float the heels.</p> <p>Staff failed to correctly implement the care plan, which could have adverse consequences for Resident #50 to include skin breakdown.</p>	F 282		
F 314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure one of three resident's reviewed during Stage II for pressure sores (Resident #13) had a brace removed in accordance with a doctor's order. The failure to discontinue a brace according to the physician's order could have contributed to delayed healing of a pressure sore.</p> <p>Findings include:</p> <p>Resident #13 was admitted to the facility on [REDACTED]/2013 after the surgical repair of a hip</p>	F 314		

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F 314 Continued From page 20

fracture in an acute care facility. The initial assessment and subsequent assessment, dated 08/15 and 8/22/2013, identified the resident was at risk for pressure ulcer development.

The physician orders at the time of admission noted the resident was non weight bearing on the right leg and used a brace (splint/immobilizer) on the right leg. The treatment sheets also noted the skin checks were to be completed once a week, however, they were not consistently documented.

Review of the progress notes documented in the clinical record found an entry dated 09/14/13 at 3:42 p.m., the Licensed Nurse on shift noted the resident complained of "pain on the right lower leg which was open skin, redness and purulent drainage."

The treatment sheet for the September noted on 09/14/13 the open area on the calf noted. The treatment sheet instructed the staff to monitor the area. On 09/15/13 an additional treatment order was initiated and the directive change dressing daily was added.

Progress notes dated 09/14/13 indicated the discovery of the wound, however, the Skin Investigative Flow Sheet (SIFS) was not initiated until 09/17/13. A notation on the SIFS described the area as "bruised RLE (right Lower extremity measuring 2x6, 2x3 and 2x5cm, attributed to leg immobilizer."

On 09/15/13 the nurse noted the resident had the "open area" and stated it was "possibly stage two pressure ulcer" described with redness and purulent drainage.

F 314 F314

How deficiency is corrected:

- Resident #13 deceased.

Measures and systems to ensure correction: 12/3/13

- All nursing staff will be in-serviced on pressure ulcer prevention, intervention, identification, timely reporting on skin concerns and following physician's orders by 12/3/13.
- The policy and procedure for use of the SIFS was reviewed by DON as well as the importance of care plan updating, coordination, and accurate/timely documentation 11/12/13.

Quality Assurance Monitoring:

- Nurse will review pressure ulcer risk assessments, skin assessments, interventions, and care plans to reflect the MDS assessments.
- The Director of Nursing will audit a minimum of 2 resident's charts per month for three months then one chart per month thereafter.

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F 314	<p>Continued From page 21</p> <p>On 09/17/13 at 11:51 a.m., the Primary Care Physician (PCP) noted the resident had a "small skin irritation on her lower leg " that was not infected and noted the "right leg splint was in place. "</p> <p>On 09/18/19 at 1:12 a.m., the nurse noted the resident had developed a "dark discoloration on the right big toe. " The entry noted the nurse contacted the orthopedic surgeon, and " received orders to remove the brace secondary to sores... "</p> <p>Subsequent entries in the progress notes between 09/19/13, through 09/21/13, found the nurses continued to documented the leg splint (immobilizer or brace) was applied even though the orthopedic surgeon had directed the staff to discontinue the use of the device.</p> <p>On 09/24/2013 the Primary Care Physician (PCP) noted the resident had "pressure sore from splint."</p> <p>The SIFS dated 09/19/2013 reported treatment was changed, however, this did not include the discontinuation of the brace.</p> <p>On 10/25/13 at 2:30 p.m., Staff B (Director of Nursing) stated if a wound is found she expected the nurse to initiate a Skin Investigative Flow Sheet (SIFS). She stated staff was expected to complete the form weekly to note the progress until the skin issue was resolved.</p> <p>See F 278 for concerns about the accuracy of the</p>	F 314		

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F 314	Continued From page 22 MDS assessment, F 280 for the lack of review of revision of the care plan after a pressure ulcer was identified, and F 514 for concerns about the accuracy of the clinical record.	F 314		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to provide therapeutic diets addressing significant weight loss and medication interaction with foods for two of four residents reviewed for nutrition (#'s 68 and 77). Findings include: RESIDENT # 68 Resident #68 was admitted on [REDACTED]/13 with diabetes, heart diseases, and edema causing excess water weight in her legs. On admission she weighed 161 pounds and was 61 inches tall, without recent weight loss and a considerable amount of edema in her legs. She was assessed without chewing or swallowing problems, and was	F 325		

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F 325 Continued From page 23

not receiving a therapeutic or mechanically altered diet. On admission she was taking a diuretic, Lasix, to reduce the leg edema with decreasing doses as her edema resolved.

Her care plan goal for nutrition was a body weight of 142 pounds plus or minus 3 pounds with expectation of loss of weight with the loss of her leg edema. As of 10/23/13 the care plan contained no entry about a significant weight loss in 180 days.

Her weights were recorded as:
Weight was 136 on 10/17/2013
Reweighed at 133 on 10/18/13
Weight 180 days ago (04/22/2013): 161 (which is 25 lbs. less than on the first date or a 18.4% loss)

A resident is determined to have significant weight loss if he/she has lost 5% or more of their weight in the last 30 days, or 7.5% or more of their weight in the last 90 days or 10% or more of their weight in the last 180 days.

The registered dietician's reassessment on 10/10/13 did not address the discrepancy between 18% and 13% loss was never explained but both values are a significant loss of over 10% loss in 180 days.

Resident #88 was observed feeding herself lunch in the dining room on 10/22/13 at 12:52 p.m. She ate more than half of the meal. "I got plenty." She was observed on 12:45pm on 10/23/13 in the dining room, said she wanted to loose weight earlier this year and is at a comfortable weight now. She was interviewed at 11:06 a.m. on

F 325 F325

How deficiency is corrected:

11/15/13

- Resident #77 was discharged.
- Resident #68, physician notified, increased weight monitoring from once a week to twice a week, and care plan revised and updated. Resident labs are within normal range and were reviewed by physician (11/5/13). In addition, licensed nursing staff were re-educated regarding food/drug interactions and need to monitor (11/12/13 by RD).

Measures and systems to ensure correction:

- An in-service education program including communication was conducted by Registered Dietitian with direct care staff addressing diets, Nutritional interventions, including the need for weight documentation and monitoring and where staff can find information on special diets by 11/15/13.

Quality Assurance Monitoring:

- RD and/or LN will review each weight report to ensure appropriate measurements are

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F 325 Continued From page 24
10/23/13 in her room, she has lost weight, wants to remain this weight, does not want to gain.

Staff G was interviewed on 10/24/13 at 7:20 a. m. about Resident #68, "She was weighed this morning, is 134 pounds. I tell the nurse the weight, she eats 50% and doesn't need a supplement. Staff G did not know that Resident #68 has had a significant weight loss in October.

The facility failed to provide notice to the staff and the medical practitioner and failed to revise care planning when Resident #68 was identified with a significant weight loss. Because there was no notice or care planning of the significant weight loss, the staff did not inform the ARNP who did not order updated laboratory tests or measures to manage her underweight status or to stop her weight loss.

RESIDENT #77
Resident #77 was admitted to the facility on 09/09/13 with multiple diagnoses including depression. The resident was admitted to the facility for rehabilitation after the surgical repair of a fractured hip. The assessment noted the resident was not on a therapeutic diet and received an anti-depressant.

Review of the resident medication regime found that he was administered an anti-depressant which can interact with certain types of foods and cause adverse side effects (i.e. high/low blood pressure), an MAOI inhibitor. The physician orders indicated the resident was on a regular diet.

Review of the vial signs sheet, that docuemnted the resident blood pressure reading daily, on

F 325

recorded and complete and to monitor weight fluctuations.

- Director of Nursing or designee will complete weekly audit for six weeks and review weight reports and residents with weight change to ensure that reasons for changes are identified and appropriate interventions have been put in place.

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F 325	<p>Continued From page 25</p> <p>10/19/13 2 3:00 pm the lowest blood pressure reading for October was noted to be 97/59, and on 10/12 at 3:43 p.m., the blood pressure was documented to be 142/82. The record showed the resident experienced wide variations in the blood pressures recorded thorough out the month, the reading recorded the month of Septemper also revealed wide variations in the resident blood pressure.</p> <p>The initial nutrition assessment dated 09/11/13, indicated the resident was on the anti-depressant and that a regular diet was appropriate. The dietitian listed the foods that needed to be omitted from the diet including aged cheeses, fermented foods, sauerkraut, corned beef, wine, beer, soybean curd. The dietitian documented "these foods are rarely served here."</p> <p>Review of the menu found cured meats were served such as sausage, ham and bacon several times a week. In addition the menu entrees included a variety of different dishes that included aged cheese such as chicken cordon blue, ham and cheese sandwiches were included on the menu. Not ensuring any dietary restrictions were implemented place the resident at risk for adverse side effects from food and medication interactions.</p> <p>The nutrition section of the care plan did identify the medication and indicated staff would educate the resident and family on limiting "high tyramine" foods. But did not identify what foods should be restricted.</p> <p>On 10/25/13 at 1:15 p.m., the Food Service Supervisor, Staff S was interviewed about what type of restriction were needed for a resident</p>	F 325		
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F 325	<p>Continued From page 26 receiving an MAOI inhibitor. The staff could not identify any foods that should be restricted.</p> <p>When asked about the resident dietary records, to determine if the restrictions had been implemented. Staff S provided a diet card that stated the resident was on a general diet. There was no information identifying what foods should be avoided, or omitted from the diet.</p> <p>The Director of Nursing Services, Staff B was interviewed on 10/25/13 at 2:30 p.m., she said the staff had discussed what kind of restrictions should be in place, but could not recall any specific information about what foods should be restricted. She then stated she could look it up if needed.</p> <p>At 2:35 p.m. Staff H, was interviewed about the diet, but was only able to identify one food that should be avoided, "cheese." The staff was not able to identify any of the other foods that should be avoided.</p> <p>The Registered Dietitian, Staff F was interviewed on 10/28/13. When asked if she had review the resident blood pressure records to assess the need for the dietary restrictions she stated no.</p> <p>On 10/28/13, at 9:00 a.m., the Nurse assigned to the unit where the resident resided, Staff K, was interviewed. He said the resident's blood pressure was sometimes high and sometimes low. The Nurse also reported the physician had not established any parameters for the nurses to notify the physician if an abnormal blood pressure was obtained.</p>	F 325		
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F 325 Continued From page 27

Review of the menu entitled Week 4 found menu items including cured meats (i.e. sausage, ham and bacon) and dishes that contained aged cheese (i.e. cheddar cheese soup, chicken cordon blue, and ham and cheese sandwiches) were also included. Not ensuring dietary restrictions were implemented placed the resident at risk for adverse side effects interactions inteactions between the food consumed and medications.

F 325

F 371
SS=E 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to ensure that foods were prepared, stored, and distributed, under sanitary conditions. Failure to meet these requirements placed residents at risk for food borne illness.

F 371

Findings include:

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F 371	<p>Continued From page 28</p> <p>Not ensuring foods were reheated to the recommended temperature</p> <p>On 10/17/13 during meal the meal observation between 12:30 and 1:30 p.m., staff were observed to reheat food items in 2 of 2 dining rooms without monitoring the temperature. The plates had been placed on the tables however the resident were not present at the time. The staff covered the plate and left them at the setting at the table. The resident arrived in the dining room approximately 15 minutes after the meal was set on the table, an unnamed Nursing Assistant removed the lid and placed the plate in the microwave. After removing the plate the temperature of the food was not tested. A similar observation was noted in the second dining area in the facility. The staff reheated food using the microwave and the temperature was not obtained.</p> <p>On 10/28/13 at 8:30 am the Dietitian stated the food should be reheated to 165 degrees when using a microwave. When asked, about the use of the microwaves for reheating foods she explained that each kitchenette in the dining room should have a thermometer available to test the temperatures. She was able to identify what the temperature should be and stated the staff had been trained to monitor the temperature when foods are a reheated.</p> <p>Soiled equipment</p> <p>During the initial tour of the food service</p>	F 371	<p>F371</p> <p><u>How deficiency is corrected:</u></p> <ul style="list-style-type: none"> Provide documented in-service training to nursing and dietary staff on proper temperature temping of reheating foods via microwave. A review of thermometer use to determine accurate temperature with return demonstration. (CNM by November 22nd) Documented in-service Dietary Staff on daily cleaning of kitchen surface areas with clear standards for compliance including kitchen door closure. (By FSD, by November 22nd) <p><u>Measures and systems to ensure correction:</u></p> <ul style="list-style-type: none"> Add in-service training of microwave reheating of foods to annual and orientation training of CNAs with return demonstration. (CNM and DNS) Updating of daily cleaning duties lists for all dietary staff to ensure focus on high touch surfaces. (CNM & FSD) FM & Dining to make improvements to exterior door access to address potential rodent entry by eliminate exterior door closing time delay on the auto open. Installing of safety door curtain on exterior door for resident safety. Installation of
ORM CMS-2567(02-99) Previous Versions Obsolete	Event ID: G58311	Facility ID WA40600	If continuation sheet Page 29 of 38

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F 371	<p>Continued From page 29</p> <p>department completed 10/17/13 at 8:45 the refrigerator doors were noted to be sticky and were visibly soiled with dried crusted food matter. Other equipment what was noted to be soiled was the interior and exterior of the microwave, the mixer had dried food matter on the base and underside of the rotary blade. The base for the blender and base for the food processor had dried food matter on the buttons and base.</p> <p>On 10/22/13 at 2:24 P.M., the microwave, blender and food processor were found in the same condition. The refrigerator handles were again noted to be heavily soiled with visible food matter.</p> <p>Failure to ensure the kitchen doors remained closed to prevent the entrance of vermin and bugs.</p> <p>During the initial tour of the kitchen completed on 10/17/13 at 8:45 a.m., the doors on the main hallway (two double doors) were propped open, using a magnet. A third door that led to a service hallway was also propped open.</p> <p>On 10/18/13 again all the doors to the food service area were propped open again. At approximately 11:00 a.m., a door adjacent to the kitchen leading to the parking lot was propped open. The exterior door remained propped open while a vendor made a delivery to the facility.</p> <p>Staff S and Staff K , (the Dietitian and Food Service Supervisor) were asked about doors being propped open. Staff S stated in general</p>	F 371	<p>exterior door alarm to alert kitchen staff for excessive time door is open. Vendor Letter regarding door propping non-compliance by delivery staff. By FMD by November 22.</p> <p><u>Quality Assurance Monitoring:</u></p> <ul style="list-style-type: none"> ▪ Random spot inspection of dining room practices conducted by both nurse managers and dietary managers including serving practices, microwave reheating of meals, use of thermometer to check reheated food temperatures will be documented on meal rounds or tray assessments. ▪ Dietary supervisor and/or Dietary Manager will monitor sanitation of doors & equipment via monthly food safety inspections. Microwave reheating of meals, use of thermometer to check reheated food temperatures ▪ Dietary supervisor and/or manager will perform daily visuals spot inspections of kitchen doors and FSD will add to monthly documented food safety audits with testing of new exterior door improvements. ▪ Results of spot checks, checklist audits will be presented to QA team for further recommendations quarterly. 	
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F 371	Continued From page 30 they remain open during hours of operation. She stated that no one had ever discussed the issue with them.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Base on observation interview and record review the facility failed to act upon a pharmacists recommendation concerning food and medication interactions for one of 5 residents (#77) reviewed for unnecessary medications. Failure to ensure that the pharacists recomendation was acted on placed the resident at risk for adverse side effects from a food and drug interaction. Findings include: RESIDENT #77 Resident #77 was admitted to the facility on [REDACTED]/13 with multiple diagnoses including depression. The resident was admitted to the facility for rehabilitation after the surgical repair of a fractured hip. The assessment noted the resident was not on a therapeutic diet and	F 428		

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F 428	<p>Continued From page 31</p> <p>received an anti-depressant. Review of the resident current medication regime found that resident was prescribed a MAOI inhibitor. The nutrition assessment noted the resident was not on a therapeutic diet. On 10/23/2013 at 9:00 a.m., Resident was interviewed as he was preparing for discharge. When asked about the anti depressant medication he was taking, he stated the medication had been prescribed for him since the early 1970's. He also reported that the physician who treated him had implemented dose reductions and the medication was half of what he used to take. On 10/2/13 the pharmacist review the resident medication regime, and forward a consult to the facility for "Nursing/Dietary Review." The consultant noted the medication and the potential for interactions with foods and other medications. The consult reference the federal guidelines in the code of Federal regulations (F-329). The facility staff reviewed the consult on 10/07/13, and a hand written notation was found documented across the bottom of the form. The notation stated "Nursing, Dietary, Medical Director on top of MAOI inhibitors."</p> <p>At 2:35 p.m. the Nurse, Staff H, who entered the notation on the consultant's report was interviewed. When asked what action was taken with the consult, Staff H reported he had discussed the issue with the physician. When asked what dietary restrictions should be implemented, the only restriction he identified was cheese and wine. He was not able to identify any of the other foods that should be avoided.</p> <p>Review of the residents care plan and dietary record revealed that no dietary restrictions were</p>	F 428	<p>F428</p> <p><u>How deficiency is corrected:</u></p> <ul style="list-style-type: none"> Resident #77 was discharged. <p><u>Measures and systems to ensure correction:</u></p> <ul style="list-style-type: none"> An in-service education program was conducted by Registered Dietitian with direct care staff addressing nutritional interventions including food and drug interaction (11/13/13). Staff was reminded of the importance to update and implement recommendations regarding food/drug interactions for all residents (11/13/13). <p><u>Quality Assurance Monitoring:</u></p> <ul style="list-style-type: none"> Nurse will identify and address any recommendations on a timely basis. An audit of medication review report will be conducted within one week of receipt to ensure recommendations are in place and reflected on resident plan of care. Documentation will be provided of action taken for any irregularity noted. Director of Nursing will review corresponding documentation for three months to ensure 	11/13/13
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(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 428	Continued From page 32 implmented at the time of admission on 09/09/13. Even though the pharamcist alerted the staff of the potential interaction with food on 10/02/13, there was no evidence the facility staff acted on the consult or reviewed the diet to ensure the restrictions were being followed. (See F 325 for the citation associated with not providing a therapeutc diet for this resident.)	F 428			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to ensure clinical records were complete and accurate for four of 25 residents reviewed (#13, 57, 61 and 50). This failure had the potentail to prevent staff from ensuring resident's care needs were met. Findings include:	F 514			

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F 514	Continued From page 33 TREATMENT ORDERS RESIDENT #13 Resident #13 was admitted to the facility on [REDACTED] 2013 after the surgical repair of a hip fracture in an acute care facility. The initial assessment, dated 08/15/2013, identified the resident was at risk for pressure ulcer development and noted the resident was extensive assistance with most activities of daily living including bed mobility, transfers, grooming dressing and hygiene. On 09/19/13 was an unscheduled assessment documented the resident had two venous ulcers. However on 09/24/13 the physician documented the resident " pressure sore from splint " Review of treatment sheet dated August 2013 noted the resident was to have weekly skin assessments related to right LE (lower extremity) incision site until healed. It also included the following statement: " skin tears, & bruises on RLE calf (3 areas measuring 2 x6, 2 x3, and 2 x 5 cm). RLE gangrenous R toe. Venous ulcer RLE. " However the first notation of any skin impairments on the right lower extremity (RLE) in the progress notes were dated 09/14/2013. On 10/25/13 at 2:30 p.m., the Director of Nursing Services, Staff B, was interviewed about August treatment record. When asked how the record for August noted the wounds that were identified in September, she stated she did not know. Staff B did provide a copy of the initial assessment completed on 08/08/13, and verified the only wounds present on admission were the surgical incisions. On 10/28/13, Staff B, stated she did not have any additional clarification concerning the August treatment sheet. Not ensuring the clinical record accurately described the resident	F 514	F514 <u>How deficiency is corrected:</u> <ul style="list-style-type: none"> Resident # 57, 50, and 61, care plans have been reviewed, revised, and updated by RN with input from resident/responsible party and IDT (11/11/13). Verification of coordination of the care plan in Accu-Nurse was completed (11/11/13). Resident #13 discharged. <u>Measures and systems to ensure correction:</u> <ul style="list-style-type: none"> Clinical record for all residents will be reviewed for accurate documentation and coordination with nurse assistance directives. All LN will be educated on proper documentation of clinical record and reminded of the importance of coordination between information systems (11/12/13). <u>Quality Assurance Monitoring:</u> <ul style="list-style-type: none"> Nurse supervisor or designee will monitor accuracy documentation of clinical record for 10% of resident's weekly for one month then every two weeks for two months. Discrepancies will be 	11/12/13

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F 514	<p>Continued From page 34</p> <p>conditions at the time they occurred created an inaccurate treatment record. Additional review of the treatment records found that even though the resident was hospitalized on 9/27/13 and 9/29/13, staff continued to document treatments were provided.</p> <p>ORAL CARE RESIDENT #57 Resident # 57 had resided in the facility multiple years with declining health related to multiple medical conditions and dementia. The resident currently required total assistance for activities of daily living and was unable to communicate his needs.</p> <p>Review of the nursing Care Plan Report revealed the resident was to have his mouth cleaned and teeth brushed after each meal and before bedtime.</p> <p>Review of the ADL Plan of Care which is used to direct nursing assistants noted oral care was provided one time on day shift and again on evening shift without reference to after meal time.</p> <p>In an interview on 10/25/13 at 2:15 p.m. Staff could neither confirm or deny the differences between the two documents intended to direct nursing care.</p> <p>In an interview on 10/28/13 at 9:00 a.m. Staff B the DNS, confirmed the discrepancy between these documents in the medical records of Resident #57. Staff stated when the care plan is updated by a licensed nurse the same changes were to be made in the ADL Plan of Care, which becomes the instruction given through the ear piece and microphone system all direct nursing</p>	F 514	<p>promptly reported to Director of Nursing.</p> <ul style="list-style-type: none"> In addition, Accu-Nurse care plans will be compared to the traditional written care plan to ensure consistency. 	
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F 514	<p>Continued From page 35 staff rely on for resident specific care instructions.</p> <p>RESIDENT #61 Resident #61 has resided in the facility since [REDACTED] 1. The quarterly comprehensive assessment (MDS) dated 3/01/13 assessed the resident to be cognitively intact. The most recent MDS dated 08/09/13 identified the resident as severe cognitive impairment and needed extensive assistance with personal hygiene.</p> <p>Review of the Care Plan Report revealed the resident was to have her mouth cleaned and teeth brushed after each meal and before bedtime. Review of the ADL Plan of Care, which is used to direct nursing assistant, revealed oral care, was monitored once on day shift and again on evening shift. Instructions did not specify after meal time.</p> <p>In an interview on 10/25/13 10:10 a.m. Staff R, nursing assistant, stated the nursing assistant help the resident with oral hygiene and follow the directions given to them through the earpiece they each wear during their shift of duty. If changes in care occur and not updated in Accunurse program then the nursing assistants may not be aware of current care needs.</p> <p>RESIDENT #50 Resident #50 was admitted to the facility 12/08/12 with care needs related to dementia. The 08/29/13 quarterly MDS identified Resident #50 needed extensive assistance with activities of daily living (ADLs) to include personal hygiene such as oral care.</p> <p>Review of the "Care Plan Report" indicated staff should "Clean mouth, brush teeth/dentures after</p>	F 514		
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F 514 Continued From page 36
meals and at bedtime." The frequency listed for this was four times per day. Review of the "ADL Plan of Care" contradicted this by directing staff to do oral care two times per day.

On 10/25/13 at 1:58 p.m. Staff G stated Resident #50 received oral care once in the morning and once at night. Staff G stated she followed the directive given in Accunurse: which was the information in the "ADL Plan of Care."

On 10/25/13 at 2:45 p.m. Staff C was asked about the differing information in the care directives and if one of them was incorrect. Staff C did not directly answer this question but stated "It should be two times a day and as needed in between."

On 10/28/13 at 8:58 a.m. Staff B acknowledged there was a difference in oral care direction within the care plan, but stated she was not sure which one was correct.

F 514

F 518
SS=D 483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS

The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview the facility failed to ensure all staff (two of four interviewed) could implement fire procedures during an

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F 518	<p>Continued From page 37</p> <p>emergency involving a fire. Failure to have staff knowledgeable about fire emergency preparedness put residents at risk for harm.</p> <p>Findings include:</p> <p>On 10/22/13 at 9:35 a.m. Staff M explained "We stay put, wait to hear if anything is happening." She then stated, "RACE" the acronym to cue her response to a fire but she did not know what the letters of "RACE" meant.</p> <p>On 10/25/13 at 1:00 p.m. Staff H could not accurately state all components involved in the response to a fire situation.</p>	F 518	<p>F518</p> <p><u>How deficiency is corrected:</u></p> <ul style="list-style-type: none"> ▪ Staff H and M were re-trained on fire emergency procedures. ▪ All staff have been in-serviced on emergency procedures and instructed regarding where to find written information to review by 11/15/13. <p><u>Measures and systems to ensure correction:</u></p> <ul style="list-style-type: none"> ▪ Random staff interviews related to emergency procedures will be conducted weekly for one month. ▪ <p><u>Quality Assurance Monitoring:</u></p> <ul style="list-style-type: none"> ▪ The facility will continue to perform random fire drills and ensure staff members are competent in emergency procedures. 	11/15/13
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STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 505504	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 10/28/2013
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F 156	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p>		

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 noted, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

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F 156	<p>Continued From Page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide the required liability and appeal notice for one of three sampled residents (#4) reviewed for liability and appeal notices. Failure to provide adequate notice had the potential to prevent this resident the opportunity to file for an appeal.</p> <p>Findings include:</p> <p>Review of Resident #4's Notice of Medicare Non-Coverage revealed her services ended 05/27/13. The signature to indicate receipt of the notice did not occur until 06/05/13. The notice was supposed to be given no later than 48 hours prior to the end of coverage.</p> <p>On 10/25/13 at 1:00 p.m. Staff D (Social Work) stated the facility's usual practice was to give the notice of non-coverage 48 hours before the termination of benefits.</p> <p>On 10/25/13 at 2:44 p.m. Staff B acknowledged the notice was not given on time.</p> <p style="text-align: right;">F156</p> <p><u>How deficiency is corrected:</u></p> <ul style="list-style-type: none"> ▪ Resident #4 responsible party was notified of Notice of Medicare Non-Coverage. <p><u>Measures and systems to ensure correction:</u></p> <ul style="list-style-type: none"> ▪ IDT will review beneficiary notices to given weekly during resident services meeting. ▪ IDT will daily communicate needs for beneficiary notices to be given. <p><u>Quality Assurance Monitoring:</u></p> <ul style="list-style-type: none"> ▪ Monthly audits of liability and appeal /notices of non coverage will be conducted by medical records for two month to ensure that notices have occurred in a timely manner according to CMS guidelines. <p style="text-align: right;">11/15/13</p>
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