

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

1240

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505251	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/20/2013
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NAME OF PROVIDER OR SUPPLIER WHITMAN HEALTH & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1150 WEST FAIRVIEW ROAD COLFAX, WA 99111
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Whitman Health & Rehab Center - Colfax on 05/13/2013, 05/14/2013, 05/15/2013, 05/16/2013, 05/17/2013, and 05/20/2013. A sample of 36 residents was selected from a census of 39. the sample included 27 residents and the records of 9 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>██████████, R.N., B. S. N. ██████████, R.N., B.S.N. ██████████, R.N., B.S.N.</p> <p>The survey team is from:</p> <p>Department of Social & Health services Aging & Long-Term Support Administration Division of Residential Care Services, District 1, Unit B Rock Pointe Tower 316 West Boone Avenue, Suite 170 Spokane, Washington 99201-2351</p> <p>Telephone: (509) 323 - 7303 Fax: (509) 329 - 3993</p> <p><i>[Signature]</i> 6/15/2013 Residential Care Services Date</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 JUN 12 2013 DSHS ADISA RCS SPOKANE WA</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE	(X6) DATE 6.12.13
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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 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F 225	<p>F-225</p> <p>1. How corrective action accomplished for the identified residents?</p> <p>Resident #43 is no longer in the facility.</p> <p>2. How you will identify other residents with the potential of being affected by the same practice?</p> <p>Investigations completed over the past month will be reviewed to identify residents with the potential of being affected by the same practice.</p>	<p>7/3/13</p> <p>7-8-13</p>
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F 225	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to investigate allegations for 1 of 2 (#43) residents that were self-medicating and hoarding prescription medications in a sample of 36 reviewed for thorough investigations. This failure placed the resident at risk for unrecognized side effects from unnecessary medications and potentially untreated drug overdoses.</p> <p>Findings include:</p> <p>Resident #43 was admitted to the facility for aftercare following a fall at her private residence. Diagnoses included [REDACTED], [REDACTED], and [REDACTED]. Per record review the facility mood assessment completed January 2013 indicated the resident often was tired, had a poor appetite, and expressed feelings of [REDACTED] and hopelessness. The resident required extensive assistance for transfers and activities of daily living.</p> <p>Review of the resident's medications noted physician orders for [REDACTED] medication, and [REDACTED].</p> <p>Review of nurse's notes on 1/14/13 evening shift indicated the resident was found in her room and was incoherent. The note stated the resident's roommate informed staff they saw the resident take something out of her bag. The staff recorded they had not administered any [REDACTED] or [REDACTED] medication on evening shift. The resident was placed in bed to sleep. Per record review of nursing notes there was no contact with the physician concerning the incident.</p>	F 225	<p>3. Address what measures will be put in place to ensure deficient practice will not recur.</p> <p>Licensed Nurses will be re-educated on completing thorough investigations and providing appropriate interventions to promote resident safety. Incidents will be reviewed by the interdisciplinary team (IDT) at the morning stand-up meeting to validate that investigations are thorough and interventions are implemented.</p> <p>4. How will the plan be monitored to ensure the solutions are sustained?</p> <p>The DNS will be responsible for the implementation and maintenance of this correction and tracking and trending concerns which will be reported to the monthly CQI committee x 3 months and PRN thereafter.</p>

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F 225	<p>Continued From page 3</p> <p>Review of a day shift nurse's notes on 1/15/13 shift reported the resident again appeared to be sedated. Per record review the facility spoke with the resident and the resident gave a prescription bottle of [REDACTED] medications to the facility for lock up until pending discharge home.</p> <p>Per review of the nurse's note indicated on 1/23/13 the resident was found wearing a [REDACTED] that was not prescribed by the facility.</p> <p>The resident was admitted to the facility for aftercare following an injury in her private residence. The resident's medication regimen included [REDACTED], pills and [REDACTED] medication. The resident was suspected of self-medicating and was found once incoherent, once wearing a non- facility [REDACTED] and suspected of hoarding [REDACTED] medication.</p> <p>The facility failed to conduct a thorough investigation of these incidents which placed the resident at risk for unrecognized side effects from unnecessary medications and potential for life threatening drug overdoses.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to respond in a dignified manner to a cognitively impaired resident and provide privacy related to</p>	F 225	<p><i>F-241</i></p> <p>1. <i>How corrective action accomplished for the identified residents?</i></p> <p>Resident #86 is receiving care in an environment that maintains her dignity.</p> <p>Staff #H will be re-educated on providing care and treatment in a manner that protects resident's dignity.</p> <p>2. <i>How you will identify other residents with the potential of being affected by the same practice?</i></p> <p>Managers will conduct routine rounds to identify residents with the potential of being affected by the same practice.</p>	7/6/13 7-8-13
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		

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F 241	<p>Continued From page 4</p> <p>a physical assessment in 1 of 1 resident (#86) in a sample of 36 reviewed for dignity.</p> <p>Findings include:</p> <p>Resident #86 was admitted on [REDACTED] 13 with diagnoses including [REDACTED]</p> <p>Per record review, the resident made several attempts each day to exit the facility. The resident wore a wander guard to alert staff. She required orientation to surroundings during episodes of confusion throughout the day.</p> <p>During periodic observation each day of the survey the resident was observed redirected several times away from exiting the facility.</p> <p>On 5/16/13 the resident was observed sitting in a chair in the dining room. An activity had just been completed and residents were milling about the room. Staff #H approached the resident and was observed to perform a nursing assessment on the resident that consisted of auscultating her lungs and abdomen with the stethoscope. When questioned by surveyor, Staff #H confirmed that she performed an assessment on the resident in the dining room. Staff #H said, "she always asks them first." She then confirmed the resident had a diagnosis of [REDACTED]. Staff #H then left the dining area with another nurse that she was newly orientating to facility practice.</p> <p>Staff #H reapproached the surveyor several minutes later in the hall by the copy room and reconfirmed the assessment by stating "The activity was over and that is why I assessed her in the dining room, and I asked her permission first."</p> <p>The resident was newly admitted to the facility and had a diagnosis that included [REDACTED]. She experienced periods of confusion and required orientation to place and time. The facility failed to</p>	F 241	<p>3. <i>Address what measures will be put in place to ensure deficient practice will not recur</i></p> <p>Staff will be re-educated on treating and caring for residents in a respectful manner that maintains the resident's dignity. Managers will conduct routine observations to validate that resident's dignity is protected. Concerns identified during these observations will be corrected immediately and will be reported at the morning stand-up meeting for appropriate action.</p> <p>4. <i>How will the plan be monitored to ensure the solutions are sustained?</i></p> <p>The Director of Nursing is responsible for the implementation and maintenance of this correction and will report concerns to the monthly CQI committee x 3 months and PRN thereafter.</p>	

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F 241	Continued From page 5	F 241			
F 279 SS=D	<p>respond in a dignified manner to the resident with a cognitive impairment in a manner that enhanced dignity and respect by performing a physical assessment in view of peers in a deemed facility community area.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</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 interview and record review it was determined the facility failed to develop care plan interventions for 1 of 36 residents (#20) related to insomnia.</p> <p>Resident #20, per record review, had sleep</p>	F 279	<p>F-279</p> <p>1. How corrective action accomplished for the identified residents?</p> <p>Resident #20's care plan has been reviewed, updated, and individualized related to her insomnia.</p> <p>2. How you will identify other residents with the potential of being affected by the same practice.</p> <p>Care plans will be reviewed to identify other residents with the potential of being affected by the same practice. Revisions will be made where indicated.</p>	<p>1-3-13 7-8-13</p>	

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F 279	Continued From page 6 apnea and was on a medication to aide with sleep. She was dependent with most activities of daily living (ADL's). Per record review, the doctor ordered a breathing machine to be worn during the night. He also requested that if she wore the machine every night she could have the medication for sleep. Per record review, the resident took the medication every night before bed, but frequently refused to wear the breathing machine at night. On 5/20/13, Staff #F reported the resident refused to wear the breathing machine most of the time. Per review of the care plan, there was no direction to the staff related to the sleeping medication or the breathing machine. The facility failed to develop an individual care plan related to her insomnia.	F 279	3. Address what measures will be put in place to ensure deficient practice will not recur. The Resident Care Manager will be re-educated to review and revise care plans as needed as well as quarterly, annually, and with change of condition after the MDS assessment has been completed. The DNS will be re-educated on reviewing the twenty-four report to identify concerns that would require changes to the resident's care plan and validate that an individualized care plan is completed.		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure licensed nurses followed professional standards of quality related to administration and documentation of prescribed medications; receiving and transcribing physician orders; consistent communication of medication changes to residents and staff; consistent monitoring of medication effectiveness. Affected were 3 of 10 residents reviewed for medications (#24, 31, 85)	F 281	4. How will the plan be monitored to ensure the solutions are sustained? The DNS is responsible for the implementation and maintenance of this correction and will report concerns to the monthly CQI committee x 3 months and PRN thereafter.		

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F 281	<p>Continued From page 7 in a sample of 36. Findings include:</p> <p>Refer to F333 Residents Free From Significant Medication Errors for additional details.</p> <p>1. Resident #24 had diagnoses including [REDACTED] and [REDACTED]. Per record review, the resident had no memory problems, confusion at times, and required extensive assistance of 1-2 staff for activities of daily living. The resident had chronic pain, received [REDACTED] medication twice daily, and had physician orders for [REDACTED] as needed.</p> <p>Review of the May 2013 Medication Administration Record (MAR) revealed Staff #I did not administer the scheduled dose of [REDACTED] medication on the evening shift of 5/7/13 because she believed the medication was unavailable. There was no information to indicate Staff #I attempted to obtain the medication from the pharmacy, informed the resident, or offered [REDACTED]. This constituted a significant medication error.</p> <p>Additional review of the [REDACTED] medication orders and May 2013 MAR revealed the following:</p> <ul style="list-style-type: none"> -On 5/8/13, different licensed nurses each wrote orders for the [REDACTED] medication. One order, signed by the physician, changed the medication to "as needed." The second order, signed by the nurse practitioner, ordered the medication to be given twice daily. -Both of the medication orders were written separately on the MAR with no dates or times to indicate the order start date. - Per the MAR, the resident received no [REDACTED] medication on 5/8, 5/9, or 5/10/13. -On 5/13/13, Staff #G wrote an order for routine 	F 281	<p>F-281</p> <p>1. How corrective action accomplished for the identified residents?</p> <p>Resident #24 is receiving her narcotic pain medication as ordered and licensed nurses are documenting medication administration in the Medication Administration Record (MAR) in accordance with professional standards of practice.</p> <p>Staff #G will be re-educated on proper procedures for re-ordering medications and to check the emergency supply for medication that is otherwise unavailable.</p> <p>Staff I will be re-educated to check with pharmacy when a medication is unavailable and to check the emergency supply for a medication that is unavailable.</p> <p>Resident #31 is no longer in the facility.</p> <p>Resident #85 is receiving medication as ordered by the physician and the medication is administered according to professional standards of practice.</p>	<p>7-3-13 7-8-13</p>
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F 281	<p>Continued From page 8</p> <p>narcotic medication which was signed by the physician.</p> <p>-Additional review of the MAR on 5/14/13 at 4:30 p.m. revealed the [REDACTED] medication was not administered as ordered on the evening of 5/13/13 and the morning of 5/14/13.</p> <p>There was no other information in the clinical record that evaluated the resident's medication plan and documented a new plan for pain medications. Based on review of the physician orders and the MAR on 5/14/13, a determination that the resident received medications as prescribed could not be made.</p> <p>The surveyor informed Staff #B on 5/14/13 at 5:00 p.m.</p> <p>Review of the facility investigation regarding the medication error revealed the following:</p> <p>-Staff #G gave the last available [REDACTED] medication dose on the day shift of 5/7/13 and did not complete the refill process.</p> <p>-On the evening of 5/7/13, Staff #I thought the medication was coming in the evening pharmacy shipment. When the medication did not arrive, Staff wrote a refill order and did not call the pharmacy and/or check the emergency medication supply. The investigation confirmed the [REDACTED] medication was available in the emergency supply on 5/7/13 and should have been administered.</p> <p>-On 5/8/13, the physician discussed medication management with the resident and changed the [REDACTED] order to "as needed." One licensed nurse inaccurately wrote the order on the order sheet and inaccurately transcribed the order on the MAR.</p> <p>-On 5/8/13, a second licensed nurse did not know that the medication was changed, wrote a refill order to continue the medication routinely, and</p>	F 281	<p>2. How you will identify other residents with the potential of being affected by the same practice?</p> <p>The Medication Administration Records will be reviewed to identify other residents with the potential of being affected by the same practice.</p> <p>3. Address what measures will be put in place to ensure deficient practice will not recur.</p> <p>Licensed nurses will be re-educated on following professional standards of practice related to administering and documenting medications and on taking appropriate action when medications are not available to administer to the resident. The DNS or designee will routinely audit the Medication Administration Records to validate that medications have been ordered, re-ordered, transcribed, administered, and documented according to professional standards of practice.</p>		

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F 281	<p>Continued From page 9</p> <p>ensured that order was signed by the nurse practitioner.</p> <p>-A licensed nurse gave the [redacted] medication as ordered on 5/13/13 and 5/14/13 but did not accurately record the medication on the MAR.</p> <p>On 5/16/13, Staff #B confirmed licensed staff had not followed the facility's procedures for professional standards related to medication services, including administration and documentation of prescribed medications, receiving and transcribing physician orders, consistent communication of medication changes to residents and staff, and consistent monitoring of medication effectiveness.</p> <p>The facility's failure to ensure licensed staff followed professional standards of quality for medications resulted in the resident missing one dose of medication and an inaccurate clinical record of medication services provided.</p> <p>2. Resident #31 had diagnoses including a [redacted] from a fall at home. Per record review, the resident had mood and behavior symptoms related to [redacted], and required extensive assistance of 1-2 staff for activities of daily living.</p> <p>Per record review, on 5/13/13 the physician ordered an [redacted] medication to be administered for 7 days for symptoms of [redacted] that was not easily managed otherwise.</p> <p>Per record review, the resident did not receive the first dose of the medication until 5/15/13, a delay of one day.</p> <p>On 5/16/13, Staff #N confirmed the first dose of the medication should have been administered on 5/14/13 and had no additional information regarding the reason for the delay.</p> <p>The facility's failure to ensure new medication</p>	F 281	<p>4. How will the plan be monitored to ensure the solutions are sustained?</p> <p>The DNS will be responsible for the implementation and maintenance of this correction and will report concerns to the monthly CQI committee x 3 months and PRN thereafter.</p>	
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F 281	Continued From page 10 orders were administered timely placed the resident at risk for a delay in treatment. 3. Resident #85, per record review, admitted to the hospital on an [REDACTED] medication and the medication was discontinued on 5/1/13. Per record review, the resident continued to receive the medication through 5/7/13. This was for 7 days after the medication was discontinued. On 5/20/13 at 1:26 p.m., Staff #F reported the orders were taken off by Staff #A. On 5/20/13 at 3:14 p.m., Staff #A reported that staff did not see the order to discontinue and they continued to give the medication. The facility failed to ensure new medication orders were taken off properly resulting in medication errors.	F 281	<i>F-315</i> 1. How corrective action accomplished for the identified residents? Resident #38 is being toileted appropriately and the care plan has been revised to provide direction for staff on how to approach if the resident refuses. Resident #75 is no longer in the facility.	7-3-13 7-8-13
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to implement interventions for 2 of 3 residents (#38, 75) reviewed for toileting in a sample of 36.	F 315	2. How will you identify other residents with the potential of being affected by the same practice? A review of residents requiring assistance with toileting will be completed to identify other residents with the potential of being affected by this practice.	

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F 315	Continued From page 11 Findings include: 1. Resident #38, per record review, had diagnoses of [REDACTED] and was on [REDACTED]. She had memory problems and was dependent on staff for her activities of daily living (ADL's), including toileting. The care plan directed staff to toilet her upon rising, before/after meals, before bedtime, and as needed. She wore briefs for occasional episodes of incontinence. On 5/14/13 at 3:30 p.m, the resident was observed shaking in bed. Staff asked her if something was wrong and she said she needed to have a bowel movement. At 3:35 p.m., Staff #Q did not offer the resident to use the toilet, but changed her brief and stated she was a check/change. On 5/15/13 at 7:20 p.m., Staff #M & Q put her to bed. They did not ask or offer her to use the toilet. They put her in bed and changed saturated brief. On 5/16/13 at 9:00 a.m., the resident was up in her wheel chair in her room and was not toileted. At 10:00 a.m., Staff #K & L placed the resident on the toilet. She stood and held the bar and was dry. She voided and was continent of urine. Staff #K reported she was generally continent for her, but at times wouldn't participate. On 5/20/13 at 1:28 p.m., Staff #F reported that the resident was supposed to be toileted before and after meals. She also said she would let people know when she needed to go. She said she had incontient episodes during the night time. On 5/20/13 after lunch the resident was not toileted. On 5/20/13 at 2:30 p.m., Staff #O reported the resident was soaked.	F 315	<p>3. Address what measures will be put in place to ensure deficient practice will not recur.</p> <p>The Nursing Assistants will be re-educated on following the care plan related to resident's toileting needs. Licensed nurse will be re-educated on supervising nursing assistants to validate that resident toileting needs are met. Nurse Managers will be re-educated on implementing interventions for toileting as part of a comprehensive, individualized plan of care to maintain/improve resident's continent status without regard for the level of support required by the resident.</p> <p>4. How will the plan be monitored to ensure the solutions are sustained?</p> <p>The DNS will be responsible for the implementation and maintenance of this correction and will track and trend concerns and report findings to the monthly CQI committee x 3 months and PRN thereafter.</p>		

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F 315	Continued From page 12 On 5/20/13 at 2:34 p.m., Staff #J reported the resident was incontinent and was to be checked/changed every 2 hours. The facility failed to implement planned interventions to maintain as much continence as possible. 2. Resident #75, per record review, had diagnoses of [REDACTED] and admitted to the facility for rehabilitation. He required extensive assistance of 2 for transfers. He admitted to the facility occasionally incontinent and became frequently incontinent. Per the facility assessment dated 1/15/13, the resident was occasionally incontinent and wore pull up briefs at all times. He was placed on a check and change program. On 5/17/13 at 10:45 a.m., Staff #E reported if a resident required 2 person assist with toileting they needed to be on a check/change program. On 5/20/13 at 10:30 a.m., Staff #A confirmed that anyone who required 2 or more assist with toileting were placed on a check/change program. The facility failed to develop strategies to ensure the resident did not decline in continence abilities.	F 315	F-323 1. How corrective action accomplished for the identified residents? Resident #17 is no longer in the facility..	1.3.13 7.8.13	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	2. How you will identify other residents with the potential of being affected by the same practice? Fall investigations for the last month will be reviewed to identify other residents with the potential of being affected by the same practice.		

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F 323	<p>Continued From page 13</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, it was determined the facility failed to provide consistent supervision to prevent a fall with fracture for 1 of 2 residents reviewed for accidents (#17) in a sample of 36. Failure to provide consistent supervision resulted in actual harm to Resident #17 who sustained a fractured right leg following a fall. Findings include:</p> <p>Resident #17 had diagnoses including a recent [REDACTED] and [REDACTED] from previous falls. Per record review, on admit the resident had some short-term memory problems, confusion, and required extensive assistance of 2 for bed mobility and transfers. The resident was impulsive, had poor safety awareness and judgment, and was at risk for falls.</p> <p>Care plan interventions to limit the risk of injury included a bed low to the floor and alarms that sounded when the resident was in bed or the wheelchair to alert staff to the resident getting up unassisted.</p> <p>Additional record review of nursing note dated 12/3/12 at 10:00 p.m. revealed the resident had progressed to requiring 1 person assist for transfers and bed mobility, was continent and using the toilet, and was using the call light to request assistance.</p> <p>Per record review, on 12/4/12 at 2:20 p.m., the resident was found on the floor in her room, holding the alarm that was still attached to her sweater and had not sounded. The resident appeared unharmed and stated she slipped out of the chair while trying to reposition herself.</p> <p>Additional record review revealed on the</p>	F 323	<p>3. Address what measures will be put in place to ensure deficient practice will not recur.</p> <p>Nursing assistants will be re-educated to report to their supervising nurse if current interventions in place to protect residents are ineffective. Licensed nurses will be re-educated to assess that interventions to protect residents are appropriate and that adequate and consistent supervision is provided to prevent injury. Nurse Managers will be re-educated on evaluating residents at risk for repeated falls, taking action to prevent further falls, appropriately care planning interventions, and validating that residents are receiving consistent, adequate supervision to prevent injury.</p> <p>The Interdisciplinary Team (IDT) will review Fall investigations weekly for the effectiveness of the interventions put in place to prevent injury. Revisions will be made as needed and reviewed weekly.</p>		

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F 323	<p>Continued From page 14</p> <p>evening shift of 12/5/12, the resident was confused and tried to self-transfer approximately 17 times. The resident took the alarm off when in her room and also attempted to self-transfer to the toilet. Staff provided 1:1 for supervision and instruction about using the call light and leaving the alarm attached, and had the resident stay at the nurse's station for increased supervision.</p> <p>Per record review, on the evening shift of 12/6/12, staff noted the resident was "still self-transferring" was confused, and had short-term memory loss. There was no information about measures the staff implemented to provide supervision.</p> <p>There was no evaluation in the clinical record of the symptoms of increased restless behavior, the inability to remember to use the call light to call for assistance, and the resident's supervision needs in light of her removing the alarm and self-transferring.</p> <p>Review of the facility investigation related to the fracture noted that on 12/8/12 during the dayshift, the resident was "up and down" and was found self-transferring to the bathroom.</p> <p>On the evening shift, the nursing assistant caring for the resident again found her removing the alarm and self-transferring. The nursing assistant placed the resident at the nurse's station while assisting other residents with dinner and explained the resident needed assistance with every transfer.</p> <p>At 7:30 p.m., the nursing assistant talked to the resident and made a plan to assist the resident to get ready for bed at 8:00 p.m. At 7:45 p.m., the nursing assistant reminded the resident she would assist her at 8:00 p.m.</p> <p>After 7:45 p.m., the resident repeatedly asked staff what her room number was and if she could</p>	F 323	<p>4. How will the plan be monitored to ensure the solutions are sustained?</p> <p>The DNS will be responsible for the implementation and maintenance of this correction and will track and trend falls and will report concerns to the monthly CQI committee x 6 months and PRN thereafter.</p>	

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F 323	Continued From page 15 go to her room. Staff advised her she could go to her room, but should not try to get ready for bed until someone helped her. At 8:00 p.m., staff heard the resident calling for help and found her partially undressed on the floor in the bathroom doorway with injury to her [REDACTED]. The alarm was on the wheelchair seat still attached to the sweater. The resident stated she was told she could use the bathroom if she needed to. The resident was transferred to the local hospital for surgery for a [REDACTED]. Despite the resident's repeated incidents of self-transfer and the nursing assistant's plan to take the resident to her room to provide care with needed supervision, other staff allowed the resident to go to her room unsupervised; at which time the resident self-transferred and fell, sustaining a significant injury due to lack of staff supervision.	F 323	F-329 1. How corrective action accomplished for the identified residents? Resident #15 has been evaluated for allergies and the antibiotic medication has been discontinued as the infection has resolved. Resident #56 has been assessed and is receiving appropriate medication related to the resident's distressed behavior. Resident #20's use of hypnotic medication has been re-evaluated and appropriate monitoring is in place.	7.3.13 7.8.13
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical	F 329	2. How will you identify other residents with the potential of being affected by the same practice? Physician orders will be reviewed to identify other residents with the potential of being affected by this practice.	

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F 329	<p>Continued From page 16</p> <p>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 the facility failed to evaluate a resident's medication allergy prior to administration, reassess effectiveness of current antibiotic therapy, reassess the dose reduction of an antipsychotic medication and re-evaluate the effectiveness of a hypnotic medication in 3 of 10 residents (#15, 20,56) in a sample of 36 reviewed for unnecessary medications.</p> <p>Findings include:</p> <p>1. Resident #15 had diagnoses that included [REDACTED], [REDACTED], and [REDACTED]. The quarterly facility assessment for April 2013 indicated the resident was at risk for pressure ulcers, required assistance with transfers and activities of daily living.</p> <p>Per record review, the resident was hospitalized in February 2013 for an infection in her [REDACTED] and [REDACTED] that were resistant to certain antibiotics. The resident was placed on an intravenous(IV) antibiotic ([REDACTED]) that the infection was known to respond too. The resident returned to the facility from the hospital with a</p>	F 329	<p>3. Address what measures will be put in place to ensure deficient practice will not recur.</p> <p>Licensed nurses will be re-educated to evaluate residents for allergies prior to administering a new medication; to assess a resident for the effectiveness of a dose reduction of an antipsychotic medication; and to appropriately monitor sleep patterns for residents receiving medication for sleep.</p> <p>The Interdisciplinary Team will be re-educated that residents who use antipsychotic drugs receive gradual dose reductions if there is no documented clinical evidence to justify the current dose in an effort to discontinue these drugs. Further, the IDT will be re-educated to monitor and reassess the dose reduction of an antipsychotic medication and to notify the physician of any adverse consequences of the dose reduction.</p>	

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F 329	<p>Continued From page 17</p> <p>peripherally inserted central [REDACTED] (PICC) line in her arm for administration of the medication and placed on contact precautions (staff to wear gloves/gowns while assisting with care, dressing changes or handling soiled linens).</p> <p>Per record review the resident pulled out her PICC line on 4/7/13. There were no further orders for continuation of the antibiotic therapy.</p> <p>Per observation of the residents record, the facility had placed a large orange sticker on the chart and Vancomycin was included on the allergy list.</p> <p>Per record review of the medical record there was no available information stating the resident did not have an allergy to [REDACTED] or have had an allergy to [REDACTED].</p> <p>Per interview with Staff # B regarding facility practice to identify allergies she said it would be listed on the sticker and included in the history, nurses notes or physician notes. In reference to the allergy listed for Resident #15 she could not identify when the allergy was identified.</p> <p>Per record review the resident was identified with antibiotic resistant infection of her nose on 4/10/13.</p> <p>She was again identified on 4/23/13 with same infection of her lungs and placed on droplet precaution (staff to wear gown/gloves and mask when the resident is actively coughing and the resident to wear a mask if actively coughing when out of bedroom).</p> <p>Per review of physician orders on 4/23/13 the resident was placed on an antibiotic to take twice daily for 30 days.</p> <p>During periodic observation of the resident during survey days she was occasionally seen out of her room wearing a mask over her mouth. No coughing was observed.</p>	F 329	<p>4. How will the plan be monitored to ensure the solutions are sustained?</p> <p>The DNS will be responsible for the implementation and maintenance of this correction and will report concerns to the monthly CQI committee x 3 months and PRN thereafter.</p>	
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F 329

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Record review of laboratory results indicated no further testing of resident had been conducted since placed on antibiotics on 4/23/13. The resident as of 5/13/13 had been on antibiotics for 20 days.

Per interview with staff #B regarding the use of antibiotic for two plus weeks and facility monitoring of effectiveness she stated they had not tested the resident and it was probably time to do so.

The resident was hospitalized for an infection and returned to the facility on IV antibiotics. The facility's chart had a sticker that identified the resident had an allergy to the medication.

The facility failed to evaluate the allergy and continued to administer the medication and failed to re-evaluate the antibiotic effectiveness and placed the resident at risk for unidentified side effects, developing complications from overuse of antibiotics and unidentified side effects related to an unnecessary medication.

2. Resident # 56 diagnoses included [REDACTED], [REDACTED], [REDACTED], [REDACTED], history of [REDACTED] in the [REDACTED] and [REDACTED] with [REDACTED] features.

Per review of the physician orders the resident received medications for the diagnoses of [REDACTED]er ([REDACTED]) and [REDACTED] for psychotic features.

Per record review the behavior committee met 3/14/2013 and stated a GDR (gradual dose reduction) would not be attempted on the residents [REDACTED] as he is a danger to others. A do not taper letter was requested by the committee.

Per record review of the behavior medication

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F 329	<p>Continued From page 19</p> <p>review form the [REDACTED] was titrated on 4/16/13 from 125 mg bid to 125 mg daily. The review further stated in the summary the resident is "consistently sexually inappropriate, 4-6 days/behaviors are well documented in nursing notes. The resident is shaking other resident's wheelchairs".</p> <p>Per record review the psychotropic medication [REDACTED] was titrated on 5/2/13 from 75 mg each p.m. to 50 mg each p.m.</p> <p>Per interview with Staff #D on 5/17/13 she said the committee did not want to taper the resident's medication as he was a danger to self and others. The tapering was a directive from corporation. They had plenty of data showing a GDR was not indicted.</p> <p>Per record review of nursing notes for May 2013 the resident's behavior continued to escalate and appetite decreased. The resident refused meals and had weight loss.</p> <p>Per record review of the resident's weight log indicated the resident weighed 163 pounds on 4/05/13 and 154 pounds on 5/13/13. The supplement Cal Dense was ordered on 5/07/13.</p> <p>Per record review the [REDACTED] was increased on 5/09/13 from 125 mg daily to bid.</p> <p>Per record review of the nurse's notes from 5/09/13 through 5/17/13 the resident continued to refuse meals, medications, strikes out at staff, and refused care.</p> <p>Per record review of nurse note on 5/15/13 the resident refused an offering of a snack and beverage because he thinks "that's drugged".</p> <p>Per interview with Staff #A on 5/17/13 she confirmed that the resident's behaviors had not indicated a GDR and it was a directive from corporation so they had to initiate it.</p> <p>The resident had a diagnosis of [REDACTED] with</p>	F 329		
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F 329	Continued From page 20 psychotic features. The facility had a behavior plan in effect and discussed GDR ' s and met regularly as a behavior committee to review medications. The resident had ongoing weight loss and expressed verbally to staff he thought his food was drugged. The facility failed to provide a supportive physical and psychosocial environment that prevented, relieved and accommodated the resident's distressed behavior related to adverse consequence of medication dose reductions. 3. Resident #20, per record review, had sleep apnea and was on a medication to aide with sleep. She was dependent with most activities of daily living (ADL's). Per record review, the doctor ordered a breathing machine to be worn during the night. He also requested that if she wore the machine every night she could have the medication for sleep. Per record review, the resident took the medication every night before bed, but frequently refused to wear the breathing machine at night. Per review of the care plan, there was no direction to the staff related to the sleeping medication or monitoring of the effectiveness of the medication. On 5/20/13 at 10:45 a.m., Staff #A confirmed there should be something on the care plan and monitoring how many hours that she slept. The facility failed to adequately monitor the use of the sleeping medication.	F 329			
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS	F 333			

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F 333	<p>Continued From page 21</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure 3 of 10 residents reviewed for medication in a sample of 36 (#24, 31, 85) were free from significant medication errors. Findings include:</p> <p>Refer to F281 Services Provided Meet Professional Standards of Quality for additional details.</p> <p>1. Resident #24 had diagnoses including [REDACTED] and [REDACTED]. Per record review, the resident had no memory problems, confusion at times, and required extensive assistance of 1-2 staff for activities of daily living. The resident had [REDACTED], received [REDACTED] medication twice daily, and had physician orders for tylenol as needed.</p> <p>Review of the May 2013 Medication Administration Record (MAR) revealed Staff #I did not administer the scheduled dose of [REDACTED] medication on the evening shift of 5/7/13 because the medication was unavailable. There was no information to indicate Staff #I attempted to obtain the medication from the pharmacy, informed the resident, or offered [REDACTED].</p> <p>In an interview on 5/13/2013 at 2:50 p.m., the resident stated on the previous weekend she did not receive her routine pain medication as prescribed. She stated she didn't think she received the [REDACTED] medication on Friday (5/9/13) and felt "terrible."</p>	F 333	<p><i>F-333</i></p> <p>1. How corrective action accomplished for the identified residents?</p> <p>Resident #24 is receiving her narcotic pain medication as ordered and licensed nurses are documenting medication administration in the Medication Administration Record in accordance with professional standards of practice.</p> <p>Staff #G will be re-educated on proper procedures for re-ordering medication and to check the emergency supply for a medication that is otherwise unavailable.</p> <p>Staff #I will be re-educated to check with pharmacy when a medication is unavailable and to check the emergency supply for a medication that is unavailable.</p>	<p>7.3.13 7.8.13</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505251	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/20/2013
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The surveyor informed Staff #B on 5/14/13, who confirmed a medication error occurred on 5/7/13.

Review of the facility investigation dated 5/16/13 revealed the following:
Staff #G gave the last available [REDACTED] medication dose on the day shift of 5/7/13 and did not complete the refill process. Staff #I thought the medication was coming in the evening pharmacy shipment. When the medication did not arrive, Staff #I wrote a refill order and did not call the pharmacy and/or check the emergency medication supply. The investigation confirmed the [REDACTED] medication was available in the emergency supply on 5/7/13.

The facility's failure to obtain and administer the pain medication constituted a significant medication error and placed the resident at risk for increased discomfort.

2. Resident #31 had diagnoses including a [REDACTED] from a fall at home. Per record review, the resident had mood and behavior symptoms related to [REDACTED] and required extensive assistance of 1-2 staff for activities of daily living.

On 5/13/13 at 3:20 p.m., the resident appeared sad and cried throughout the interview.

Per record review, on 5/13/13 staff talked with the resident and notified the physician of the resident's symptoms. The physician ordered an [REDACTED] medication to be administered for 7 days for symptoms of [REDACTED] that was not easily managed otherwise.

Per record review, the resident did not receive the first dose of the medication until 5/15/13, a delay of one day.

On 5/16/13, Staff #N confirmed the first dose of the medication should have been administered

F 333

2. How you will identify other residents with the potential of being affected by the same practice?

The Medication Administration Records will be reviewed to identify other residents with the potential of being affected by the same practice.

3. Address what measures will be put in place to ensure deficient practice will not recur

Licensed nurses will be re-educated on following professional standards of practice related to administering and documenting medications and on taking appropriate action when medications are not available to administer to the resident. The DNS or designee will routinely audit the Medication Administration Records to validate that medications have been ordered, re-ordered, transcribed, administered, and documented according to professional standards of practice.

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F 333	Continued From page 23 on 5/14/13 and had no additional information regarding the reason for the delay. This constituted one significant medication error and placed the resident at risk for a delay in treatment. 3. Resident #85, per record review, admitted to the hospital on an [REDACTED] medication and the medication was discontinued on 5/1/13. Per record review, the resident continued to receive the medication through 5/7/13. This was for 7 days after the medication was discontinued. On 5/20/13 at 1:26 p.m., Staff #F reported the orders were taken off by Staff #A. On 5/20/13 at 3:14 p.m., Staff #A reported that staff did not see the order to discontinue and they continued to give the medication. The facility failed to ensure the resident was free of any significant medication errors.	F 333	4. <i>How will the plan be monitored to ensure the solutions are sustained?</i> The DNS will be responsible for the implementation and maintenance of this correction and will track and trend falls and report concerns to the monthly CQI committee x 3 months and PRN thereafter.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	F-441 1. <i>How corrective action accomplished for the identified residents?</i> Resident #'s 38 and 68 are receiving proper peri care and correct handling of linens. Staff #'s Q, P, and M will be re-educated on the proper method of providing peri care and handling linens.	7-13-13 7-8-13

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F 441	<p>Continued From page 24</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure staff performed proper peri care/handling of linens for 2 of 3 residents (#38, 68) in a sample of 36 at risk for the spread of infection. Findings include:</p> <p>1. During observations of peri care for Resident #38 on 5/14/13 at 3:35 p.m., Staff #Q provided peri care and used the same side of the cloth several times around her [REDACTED] opening. He then threw the linen on the floor. She was turned to the other side and Staff #P finished the peri care and used the same side of the wash cloth several times and wiped from back to the</p>	F 441	<p>2. <i>How will you identify other residents with the potential of being affected by the same practice?</i></p> <p>The Staff Development Coordinator will observe nursing assistants providing peri care and handling linens to identify other residents with the potential of being affected by the same practice.</p>		

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F 441	<p>Continued From page 25 front of the [REDACTED] opening.</p> <p>2. During observations of peri care for Resident #68 on 5/14/13 at 4:00 p.m., Staff #M provided peri care and used the same side of the cloth across the opening of his [REDACTED].</p> <p>On 5/16/13 at 2:24 p.m., Staff #B reported the facility had a high incidence of [REDACTED] ([REDACTED]). She discussed that the new nursing assistants were never checked off before they went to the floor for peri care, but that the new staff were placed with a seasoned nursing assistant. She reported that she has not observed peri care that the staff provided.</p> <p>The facility failed to ensure that staff implemented measures to prevent the spread of infection.</p>	F 441	<p>3. Address what measures will be put in place to ensure deficient practice will not recur.</p> <p>Nursing assistants will be re-educated on the correct method to provide peri care and handle linens for incontinent residents to prevent the spread of infection. The Staff Development Coordinator will conduct skills checks on new nursing assistants prior to allowing them to provide peri care to residents and will conduct random observations to validate that the nursing assistants are providing peri care and handling linens correctly to prevent the spread of infection.</p> <p>4. How will the plan be monitored to ensure the solutions are sustained?</p> <p>The DNS will be responsible for the implementation and maintenance of this correction and for tracking and trending concerns which will be reported to the monthly CQI committee x 3 months and PRN thereafter.</p>