

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

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

1241

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505372	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/18/2013
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NAME OF PROVIDER OR SUPPLIER CANYON LAKES RESTORATIVE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2702 SOUTH ELY KENNEWICK, WA 99337
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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	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Canyon Lakes Restorative and Rehabilitation Center on 07/15/13, 07/16/13, 07/17/13 and 07/18/13. A sample of 41 residents was selected from a census of 49. The sample included 28 current residents and the records of 13 former and/or discharged residents.</p> <p>The survey was conducted by: [REDACTED] RD [REDACTED] RN [REDACTED] RN [REDACTED], RN</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Long-Term Support Administration Residential Care Services, District 1, Unit C 3611 River Road, Suite 200 Yakima, WA 98902</p> <p>Telephone: (509) 225-2800 Fax: (509) 574-5597</p> <p><i>[Signature]</i> Residential Care Services Date</p>	F 000	<p style="text-align: right;">Received Yakima RCS AUG 12 2013</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>Administrator</i> (X6) DATE 8-9-13
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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 272 SS=E	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p>	F 272	<p>This Facility will conduct an initial and periodic comprehensive assessment for hydration and for use of assistive mobility devices (transfer poles) used at bedside.</p> <p>A). Hydration Status</p> <ul style="list-style-type: none"> • A hydration assessment will be completed on Resident #23. • Hydration assessments will be completed on each resident as necessary, when reviewing I&O records as well as concurrently with each MDS. • Nursing staff involved with completion of hydration assessments will be inserviced on addressing dehydration. <p>B). Transfer Poles (assistive mobility devices at the bedside)</p> <ul style="list-style-type: none"> • A bed mobility device assessment and informed consent that identifies potential risks and benefits will be completed on Residents #5 and #37. • A bed mobility device assessment and informed consent identifying potential risks/benefits will be completed on all residents currently using a transfer pole. • Restorative and skilled therapy staff will be inserviced on use of these assessments. <p>The Director of Nursing and the Restorative Department Coordinator will be responsible for ensuring this correction.</p>	8/30/13	

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F 272

Continued From page 2

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to perform assessments for A) hydration status for 1 of 1 resident (#23) in the sample who was identified at risk for dehydration; and B) for 2 of 2 residents (#37, 5) in the sample with transfer poles (assistive mobility devices at the bedside). Findings include:

A. Resident #23. Multiple diagnoses included [REDACTED] and [REDACTED]

On 07/15/13 at approximately 1:20 p.m. the resident was lying on her bed. Her skin was dry and she stated she was thirsty. There was no water at the bedside.

Review of the plan of care noted she was on a fluid restriction of 40 ounces per day.

The Intake/Output (I&O) form between 06/23/13 and 07/15/13 revealed her average daily fluid intake was 22 ounces, less than the allowed amount per day.

The most recent assessment of the resident's hydration status was dated 10/25/12. The most recent assessment by the Registered Dietitian was 04/11/13 and noted the resident's estimated fluid needs were 45 ounces per day, with adjustment to 40 ounces per day.

Interview with Staff Member E, a Licensed Nurse on 07/16/13 at approximately 11:45 a.m. noted she performed hydration assessments on residents who were on I&O "to see if they can come off I&O"; however, if a resident was always

F 272

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F 272	<p>Continued From page 3 on I&O, then she did not do the assessment.</p> <p>On 07/16/13 at approximately 11:50 a.m., Staff Member C, a Licensed Nurse, stated either she or Staff E would do the hydration assessments and if a resident was not on I&O the hydration assessments would be done quarterly. She was unable to find a hydration assessment for the resident.</p> <p>B. Resident #37. Review of the medical record revealed the resident had multiple diagnoses including new [REDACTED] attack and [REDACTED]</p> <p>On 07/15/13 a transfer pole was observed located on the left side (if facing the bed while standing at the foot of the bed) of Resident #37's bed. The metal transfer pole was secured between the floor and the ceiling. The pole was approximately 9 inches out from the side of the bed and approximately 29 inches down from the headboard of the bed. The pole was observed in approximately the same position on each day of the survey (07/15/13 through 07/18/13).</p> <p>Record review on 07/18/13 of a comprehensive assessment completed on 06/25/13 documented Resident #37 was not steady and required staff assistance to move from a seated to standing position. Resident #37's ability to use the transfer pole safely was not assessed.</p> <p>On 07/18/13 at approximately 11:30 a.m. Staff Member A, Restorative/Rehabilitation Nursing Director stated Resident #37 had a transfer pole. She acknowledged her evaluation for Resident #37 did not include safe use of a transfer pole.</p>	F 272			

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F 272	<p>Continued From page 4</p> <p>Resident #5. Review of the medical record revealed the resident had multiple diagnoses including a history of [REDACTED]</p> <p>Per record review on 07/18/13 of a comprehensive assessment dated 05/20/13 revealed Resident #5 was not steady and required staff assistance to move from a seated to standing position. No current assessment of Resident #5's ability to use the transfer pole safely was found in the medical record.</p> <p>On 07/15/13 a transfer pole was observed located on the left side (if facing the bed while standing at the foot of the bed) of Resident #5's bed. The metal transfer pole was secured between the floor and the ceiling. The pole was approximately 9.5 inches out from the side of the bed and approximately 28 inches down from the headboard of the bed. The pole was observed in approximately the same position on each day of the survey (07/15/13 through 07/18/13).</p> <p>On 07/18/13 at approximately 11:15 a.m. Staff Member C, a licensed nurse and assessment coordinator stated transfer poles are used if it helps to increase a resident's independence with transfers. She further stated she evaluated mobility and transfer status, but not specifically related to the transfer pole.</p> <p>On 07/18/13 at approximately 11:30 a.m. Staff Member A, Restorative/Rehabilitation Nursing Director stated she evaluated strength and mental capability with regard to transferring skills but did not assess safety to use transfer pole.</p>	F 272		
F 279	483.20(d), 483.20(k)(1) DEVELOP	F 279		

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F 279 SS=D	<p>Continued From page 5</p> <p>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 observation, interview and record review, the facility failed to develop a comprehensive plan of care that included measurable objectives to meet a resident's medical needs for 1 of 1 resident (#31) in the sample. Without a comprehensive, complete care plan in place, this resident was at risk for not reaching her highest potential. Findings include:</p> <p>Resident #31. Admitted with a [REDACTED] and [REDACTED]. The assessment dated 01/13/13 included the resident was weight bearing and able to transfer with</p>	F 279	<p>This facility will develop comprehensive plans of care that include measurable goals to meet the medical needs of all residents.</p> <p>The comprehensive plan of care will be updated for Resident #31 and will reflect needs based on her most recent comprehensive assessment.</p> <p>The comprehensive plans of care for all current residents will be reviewed and updated to reflect their needs based on their most recent comprehensive assessment.</p> <p>All disciplines involved with care planning will be inserviced on the development and updating of the comprehensive plan of care including identification of measurable goals to meet the medical needs of each resident that will allow them the ability to attain or maintain their highest potential.</p> <p>The Director of Nursing/Resident Care Manager will be responsible for ensuring this correction.</p>	8/30/13
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F 279	<p>Continued From page 6</p> <p>assistance and that when fluids were placed in reach the resident could grasp the cup and drink fluids.</p> <p>An assessment on 04/30/13 included a significant decline resident's ability to transfer and eat independently. The care plan dated 03/04/13 did not identify resident decline in ability to drink fluids or develop approaches and interventions to assist the resident to receive adequate fluid intake.</p> <p>There was no care plan update for the 04/30/13 assessment that had identified a change in weight bearing status from assistance with transfers to total assistance with transfers.</p> <p>The resident had experienced recurrent [REDACTED] on 04/26/13, 05/16/13 and 07/01/13 and had required treatment with [REDACTED] (an injectable antibiotic).</p> <p>The 05/21/13 assessment by the dietitian included the resident's [REDACTED] and the decreased fluid intake. A review of Resident #31's plan of care revealed that there were no identified approaches or interventions to address the resident's [REDACTED].</p> <p>Between 07/17/13 and 07/19/13, the resident's mucous membranes were dry and pale; the tongue was not moist and was tacky.</p> <p>On 07/17/13 at 12:55 p.m. Staff Member H, stated we "have to encourage her to drink fluids during meals and that depends on her. She was able to pour her water from her water pitcher but she is unable to do that now."</p>	F 279		
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F 279	Continued From page 7 On 07/18/13 at approximately 11:45 a.m. Staff Member C, stated "the care plans were not updated and the Director of Nursing was working to catch them up."	F 279		
F 280 SS=D	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 interview and record review, the facility failed to ensure comprehensive plans of care were developed within 7 days after completion of the comprehensive assessment, in accordance with CFR 483.20(k)(2), for 3 of 3 residents (#71, 37, 65) in the sample who were admitted in the past 30 days. Without comprehensive, complete	F 280	This facility will develop a comprehensive care plan for newly admitted residents within 7 days after completion of the comprehensive assessment (by day 21). The appropriate disciplinary staff will identify the individualized needs with measurable goals and interventions that will allow newly admitted residents the ability to reach their highest potential. Comprehensive plans of care will be developed for Resident #71, #37 and #65. A comprehensive plan of care will be developed by Day 21 on all future newly admitted residents. The Director of Nursing/ Resident Care Manager will be responsible for ensuring this correction.	8/30/13

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F 280	<p>Continued From page 8</p> <p>care plans in place, the residents were at risk for not reaching their highest potential. Findings include:</p> <p>Resident #71. Admitted [REDACTED] 13 with multiple diagnoses including [REDACTED], [REDACTED] and [REDACTED]. The comprehensive assessment, dated 07/07/13, noted the resident had a fall at home on 06/11/13.</p> <p>A Fall Risk Assessment, dated 06/27/13, noted the resident was at high risk for falling. She was weak upon admission, after being in the hospital for 9 days, and therapy was started.</p> <p>Review of the plan of care noted a temporary care plan, which checked specific directives for staff to follow, such as the type of transfers and mobility assistance the resident required. No fall interventions were identified.</p> <p>Although the resident was admitted 22 days prior, there was no comprehensive plan of care in place, which identified the resident's needs with measurable goals and interventions.</p> <p>Interview with the Resident Care Manager and Licensed Nurse, Staff E on 07/16/13 at 2:20 p.m., revealed the Director of Nurses was "working on the care plans." Interview with the Director of Nursing (Staff F) at 2:30 p.m. noted "I am working on it; I am busy with two admissions right now."</p> <p>Resident #65. Admitted [REDACTED] /13 with diagnoses including [REDACTED] with [REDACTED].</p> <p>The resident was assessed on 06/27/13 to be mostly non-verbal, cognitively impaired and resistive to cares by staff.</p>	F 280		
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F 280	<p>Continued From page 9</p> <p>Medication was given in liquid form to include [REDACTED] medication) and [REDACTED], an [REDACTED]</p> <p>A review of the "temporary admission care plan" dated 06/20/13 provided a check off of directives for staff to follow, such as monitoring mood symptoms (resistive to cares and crying), and alert nursing staff or social services if mood declines.</p> <p>There was no comprehensive care plan with individualized interventions and measurable goals 29 days after the resident was admitted to the facility.</p> <p>On 07/18/2013 at 2:45 p.m., Staff Member C said they "were behind in care plans and were trying to catch up."</p> <p>Resident #37. Admitted [REDACTED]/13 with multiple diagnoses including [REDACTED]</p> <p>The nursing admission assessment noted multiple bruises present on resident's abdomen, lower and upper extremities.</p> <p>Review of the medical record revealed a temporary care plan. The care plan identified Resident #37 had fragile skin and bruised easily; however, it did not identify protective measures for her fragile skin.</p> <p>Further, the resident had a fall/safety assessment that was undated. The assessment identified Resident #37 to be at high risk for falls.</p> <p>The temporary care plan directed two staff to</p>	F 280		
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F 280	Continued From page 10 assist Resident #37 with transfers but identified no other interventions to reduce her risk of falling. On 07/17/13 at approximately 10:50 a.m. Staff Member F, Director of Nursing Services stated she was working on a care plan for Resident #37. She stated the reason the care plan was late was because one of the nurses left recently. Staff Member F said she was doing the care plans until the staffing vacancy could be resolved.	F 280		
F 323 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on interview, record review and observation the facility failed to provide adequate supervision to mitigate the risk of an accident for 2 of 7 residents (#37, 5) sampled for use of transfer pole . The facility failed to assess the potential hazards and to take steps to reduce or eliminate those hazards before placing a ceiling to floor transfer pole near the residents' beds. That placed the residents at risk for potential entrapment between the bed and the pole. Findings include: Resident #37. Review of the medical record revealed the resident had multiple diagnoses	F 323	This facility will continue to ensure that the resident environment is as free of accident hazards as possible. Bed mobility device assessments and informed consents (which identify potential risks (hazards) as well as the benefits regarding the use of transfer poles) are completed on residents who would benefit from the use of a transfer pole which will better assist them with bed mobility without risk for potential entrapment between the bed and the transfer pole. Resident ability to safely use a transfer pole will be assessed by a skilled therapist (PT/OT) prior to placement of pole at bedside at a distance that is less than 2 1/3 inches or greater than 12 inches from the side of the bed frame to the transfer pole. A bed mobility device assessment and informed consent have been completed for Residents #5 and #37 and will also be completed for other residents who are currently using a transfer pole.	8/30/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505372	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/18/2013
NAME OF PROVIDER OR SUPPLIER CANYON LAKES RESTORATIVE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2702 SOUTH ELY KENNEWICK, WA 99337	
(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 323	<p>Continued From page 11 including new [REDACTED] and [REDACTED]. Per her care plan she required extensive staff assistance to transfer from bed to chair. An undated fall/safety assessment identified Resident #37 as exhibiting unsafe transfer skills daily and unsafe bed mobility (defined on the assessment as restless movement, scooting to the end of the bed, etc.).</p> <p>Medical record review on 07/18/13 revealed Resident #37's ability to use the transfer pole safely was not assessed. There was no guidance on safe placement of the transfer pole in relation to the bed in the medical record.</p> <p>On 07/15/13 a transfer pole was observed located on the left side (if facing the bed while standing at the foot of the bed) of Resident #37's bed. The pole was metal and was secured between the floor and the ceiling. The pole was approximately 9 inches out from the side of the bed and approximately 29 inches down from the headboard of the bed. The pole was observed in approximately the same position on each day of the survey (07/15/13 through 07/18/13).</p> <p>Resident #5. Review of the medical record revealed the resident had multiple diagnoses including a history of [REDACTED] a [REDACTED] and [REDACTED] and [REDACTED]. Per her care plan she required extensive staff assistance to transfer from bed to chair. A fall/safety assessment dated 05/20/13 identified Resident #5 as having unsafe bed mobility (defined on the assessment as restless movement, scooting to the end of the bed, etc.).</p> <p>Per record review on 07/18/13 no current assessment of Resident #5's ability to use the</p>	F 323	<p>Facility will continue to perform bed mobility device assessments and informed consents on newly admitted residents or current residents who would benefit from the use of a transfer pole at the bedside.</p> <p>The Restorative Department Coordinator will be responsible for ensuring this correction.</p>	

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

PRINTED: 07/30/2013
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F 323	<p>Continued From page 12</p> <p>transfer pole safely was found in the medical record. There was no guidance on safe placement of the transfer pole in relation to the bed.</p> <p>On 07/15/13 a transfer poles was observed located on the left side (if facing the bed while standing at the foot of the bed) of Resident #5's bed. The pole was metal and was secured between the floor and the ceiling. The pole near Resident #5's bed was approximately 9.5 inches out from the bed and approximately 28 inches down from the headboard. The pole was observed in approximately the same position on each day of the survey (07/15/13 through 07/18/13).</p> <p>On 07/17/13 at approximately 12:00 p.m. Staff Member A, Restorative/Rehabilitation Nursing Director stated she evaluated residents to determine if a transfer pole would be helpful to them. If a transfer pole would be beneficial, she requested that maintenance staff install a pole. She stated she did not designate where the pole should be placed in relation to the bed.</p> <p>On 07/17/13 at approximately 12:30 p.m. Staff Member B, Maintenance Supervisor stated the beds all have locking wheels. He stated he installed the transfer poles when requested, but said there was not a protocol for where to place them in relation to the bed. He stated he just "puts them up and lets nursing move the bed to the right place."</p> <p>On 07/18/13 at approximately 11:15 a.m. Staff Member C, a licensed nurse and assessment coordinator stated they did not determine what the safe distance would be between the transfer</p>	F 323		

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

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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER CANYON LAKES RESTORATIVE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2702 SOUTH ELY KENNEWICK, WA 99337
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F 323	Continued From page 13 pole and the bed. She stated there was no method to communicate the correct positioning of the bed and pole to those who might move the bed. On 07/19/13 at approximately 9:45 a.m. Staff Member D, Housekeeping Supervisor stated they would move the beds in the resident rooms while cleaning. She stated they try to put them back where they were but they have not received any direction about how to re-position the moved bed in relation to the transfer pole. On 07/18/13 at approximately 11:30 a.m. Staff Member A stated she did not know how the transfer pole should be placed in relation to the bed. She stated she needed more information about how to assess the risks and benefits and how to position the transfer pole.	F 323		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure 2 of 2 residents (#23, 31) in the sample received adequate fluids to maintain proper hydration and decrease the potential for urinary tract infections. Findings include: Resident #23. Multiple diagnoses included [REDACTED] and [REDACTED]. The	F 327	This facility will assure that each resident receives sufficient amounts of fluids based on individual needs to prevent dehydration, maintain proper hydration and decrease potential for UTIs. A hydration assessment will be completed for Residents #23 and #31 that will identify dehydration risk factors and those factors identified will be addressed on plan of care. Hydration assessments will be completed on each resident as necessary, when reviewing I&O records as well as concurrently with each MDS. Hydration policy will be reviewed with all nursing staff.	8/30/13

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

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F 327	<p>Continued From page 14</p> <p>resident had two [REDACTED] in the past two months, which were treated with antibiotics. The physician ordered a fluid restriction of 40 ounces per day.</p> <p>The plan of care identified the resident was at risk for dehydration due to the restriction of fluids. The goal was that she would have no signs or symptoms of dehydration as evidenced by her skin returning "quickly on forehead and sternum." Also, her laboratory values would remain within normal limits. She was to have no water pitcher at the bedside, although staff was to notify the licensed nurse if the resident did not drink all her fluids at mealtimes.</p> <p>On 07/15/13 at approximately 1:20 p.m. the resident was resting on her bed; there was no water pitcher at the bedside. Her skin was dry and she stated to the surveyor she was thirsty.</p> <p>Review of the Medication Administration Record (MAR) noted the resident could receive 23 ounces with meals.</p> <p>On 07/16/13 during the noon meal, the resident received approximately 3 ounces of liquid with her meal. The dietary card noted she could have 7 ounces with each meal. There was one glass on her tray, which a nursing assistant identified could hold 4 ounces.</p> <p>Review of the Intake/Output record between 06/23/13 and 07/15/13 noted the resident's average daily intake was 22 ounces; that was approximately half of her allowed fluid intake.</p> <p>There was no evidence in the medical record that staff had reviewed the resident's hydration status</p>	F 327	<p>Nursing staff involved with completion of hydration assessments will be inserviced on addressing dehydration risk factors and the potential for UTIs.</p> <p>The Director of Nursing will be responsible for ensuring this correction.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 327	<p>Continued From page 15</p> <p>since 10/25/12, although the Director of Nursing (Staff F) and the Resident Care Manager (Staff C) both stated it should be done quarterly. There was no documentation stating whether the resident refused fluids.</p> <p>Resident #31. Diagnoses included a [REDACTED], [REDACTED] and [REDACTED]. According to the resident assessment dated 04/30/13 the resident had a significant change of condition and required one person physical assistance for eating. The resident also rejected cares from the nursing staff including refusing oral medications and meals. The resident's diet was a regular texture with small portions and thin fluids.</p> <p>The resident experienced [REDACTED] ([REDACTED]) 04/26/13, 05/17/13 and 07/01/13 and was treated with an injectable antibiotic.</p> <p>The dietary follow-up note on 05/21/13 documented the resident had [REDACTED] and should be encouraged to take fluids, and needed 56 ounces a day.</p> <p>Between 07/17/13 and 07/19/13, the resident was sitting in her wheelchair with her eyes closed and mouth open. The outside of the resident's mouth was pale and dry mucous membranes; the tongue was not moist and was tacky.</p> <p>During the lunch hour on 07/17/13, Resident #31 was assisted by a staff member to eat and drink fluids. The resident refused the meal and only drank 2 ounces of a health shake.</p> <p>The resident refused lunch on 07/18/13 and drank a total 8 ounces of fluids.</p>	F 327		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505372	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/18/2013
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F 327	<p>Continued From page 16</p> <p>The average fluid consumption from 07/01/13 through 07/16/13 was 11 ounces with daily amounts ranging from 22 ounces to 2 ounces, which is well below her estimated daily fluid needs of 56 ounces.</p> <p>Observations of resident being offered fluids in between meals by staff from 07/17/13 through 07/18/13 indicated that the medication nurse gave sips of water at the morning and noon medication pass. The resident spit out the morning medications on those dates. There were no other staff observed offering fluids to the resident in between meals.</p> <p>On 07/18/13 at approximately 11:00 a.m. Staff Member C stated "spitting out of medications and fluids during medication pass has been a challenge to the nursing staff. We have discontinued medications the resident had refused on a continual bases and have made adjustments."</p> <p>On 07/17/13 at 11:30 p.m. Staff Member K, stated the resident "has [REDACTED] and the behaviors the resident exhibits are hitting, spitting, kicking and biting. Resident refuses her medications and they have discontinued her other medications due to her refusals of oral medications. The resident does refuse her fluids at times."</p> <p>On 07/17/13 at 12:55 p.m. Staff Member H, stated we "have to encourage her to drink fluids during meals and that depends on her. She was able to pour her water from her water pitcher but she is unable to do that now. The resident's spouse does come in at breakfast and tries to encourage fluids but that doesn't always work."</p>	F 327		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505372	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/18/2013
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NAME OF PROVIDER OR SUPPLIER CANYON LAKES RESTORATIVE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2702 SOUTH ELY KENNEWICK, WA 99337
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F 327	Continued From page 17	F 327		
F 329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility</p>	F 329	<p>Facility will ensure that residents are free of unnecessary drugs with the assistance of a consultant pharmacist.</p> <p>Consultant pharmacist will re-evaluate the medication regimens of Residents #50 and #55. The recommendations will be reviewed with the physicians for potential tapering as recommended by the pharmacist and will be addressed.</p> <p>Consultant pharmacist will review the medication regimens of all remaining current residents and make recommendations as appropriate that will be reviewed by their physicians.</p> <p>Residents receiving PRN anti-anxiety medications have behavior monitoring forms in place that are completed every shift and identify the non-medical interventions tried by the licensed nursing staff prior to using the PRN anti-anxiety medications.</p> <p>Licensed nursing staff will be inserviced on proper utilization of non-medical interventions versus use of PRN anti-anxiety medications.</p> <p>The Director of Nursing will be responsible for ensuring this correction.</p>	8/30/13

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

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F 329	<p>Continued From page 18</p> <p>failed to ensure 3 of 3 residents (Residents #18, 50, 55) in the sample of 10 who were reviewed for unnecessary drugs were free of unnecessary drugs by not reviewing with the physician for potential tapering as recommended by the pharmacist, failure to include non-medicinal interventions before use of anti-anxiety medication and re-evaluating for further lowering the dose of a hypnotic medication that was received for over a year. Findings include:</p> <p>Resident #55. The [redacted] year old resident was admitted in [redacted] 2012 with diagnoses which included [redacted] and [redacted].</p> <p>The plan of care identified the resident's diagnosis of [redacted] and staff was to monitor her symptoms quarterly. The most recent mood assessment was in April 2013 and noted the resident had no symptoms of [redacted]. Review of the pharmacist's recommendations revealed that in April 2013 s/he had recommended a taper (gradual dose reduction) of the [redacted]. However, there was no evidence the facility staff discussed the recommendation with the physician and the resident continued to receive the [redacted].</p> <p>Resident #18. The resident was admitted in [redacted] 2013 with multiple diagnoses including [redacted] and [redacted]. The progress notes documented on 07/07/13 at 3:05 p.m. the Licensed Nurse (LN) administered an [redacted] medication to the resident for symptoms of [redacted]. No specific anxiety symptoms were documented. There was no evidence non-medication interventions were attempted prior to administering the [redacted] medication. Additionally the June 2013 Medication Administration Record (MAR) noted</p>	F 329		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 329	<p>Continued From page 19</p> <p>the resident was given the [REDACTED] medication on June 15 at 7:00 p.m. and June 17 at 12:00 p.m. for [REDACTED] calling out and "tearful" behavior without evidence of behavioral interventions attempted prior to administration the medication.</p> <p>Resident #50. Review of the psychotropic medication monthly evaluations noted the resident was administered [REDACTED] 2.5 mg (a [REDACTED] medication) every night for [REDACTED] since 07/31/12.</p> <p>Progress notes dated 06/11/12 noted the [REDACTED] medication had been decreased from 5 mg to 2.5 mg (more than one year ago). The [REDACTED] reviews noted the resident slept an average of 6 to 8 hours per night.</p> <p>There was no evidence the facility staff discussed with the physician the continued necessity of the current dose without attempting or consideration of the possibility of tapering the sleeping medication or evidence of justification for continued current dose over a year.</p>	F 329		
F 428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p>	F 428	<p>The drug regimen of each resident will be reviewed at least once a month by a licensed pharmacist.</p> <p>Consultant pharmacist will re-evaluate the medication regimen on Resident #50 for a gradual dose reduction of Zolpidem (hypnotic medication).</p> <p>Recommendation will be reviewed with Resident #50's physician and will be addressed based on his response to the recommendation.</p>	8/30/13

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 428	<p>Continued From page 20</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure the pharmacist provided recommendations for 1 of 3 residents (#50) in the sample of 10 who received a hypnotic medication without a gradual dose reduction for over one year. Findings include:</p> <p>Resident #50. Review of the [REDACTED] medication monthly evaluations noted the resident was administered [REDACTED] 2.5 mg (a [REDACTED] medication) every night for [REDACTED]. The last taper for this medication was on 06/11/12 from 5 mg to 2.5 mg (over one year ago). The [REDACTED] reviews noted the resident slept an average of 6 to 8 hours per night.</p> <p>The pharmacist's monthly medication review for January to June 2013 noted no recommendations related to the use of the [REDACTED] medication for potential attempt for tapering to the lowest effective dose, in spite of the resident sleeping an average of 6 to 8 hours.</p>	F 428	<p>Consultant pharmacist will review the medication regimens of all current residents who are receiving a hypnotic medication that may need a gradual dose reduction. Recommendations will be reviewed and addressed based on physician responses.</p> <p>The Director of Nursing will be responsible for ensuring this correction.</p>	
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