

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

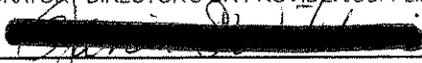
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PRINTED: 11/27/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505347	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/15/2013
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB CENTER- LAKEWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 11411 BRIDGEPORT WAY TACOMA, WA 98499
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Off-hours Quality Indicator Survey conducted at Kindred Transitional Care and Rehabilitation-Lakewood on 11/4/13, 11/5/13, 11/6/13, 11/7/13, 11/8/13, 11/12/13, and 11/13/13. The survey included data collection Tuesday 11/12/13 between 4:55 a.m. and 4:00 p.m. A sample of 38 residents was selected from census of 75. The sample included 33 current residents and the records of 5 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>██████████ RN, BSN, MSN ██████████ RN, MN ██████████ RN, BSN ██████████ PhD, RN, MS, MSN, APFNS</p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging and Long- Term Support Administration Residential Care Services, District 3, Unit A P.O. Box 45819, MS: N27-24 Olympia, WA 98504-5819</p> <p>Telephone: (253) 983-3800 Fax: (253) 589-7240</p> <p> 11-27-13 Signature Date</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 12/31/13
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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 176 SS=D	<p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to determine that self-administration of a medication was a safe practice for 1 of 38 sampled residents (#75) reviewed for care and services when the resident self-administered eye drops for glaucoma without an assessment or care plan for the practice. This failure placed the resident at risk for unsafe administration of the medication.</p> <p>Findings include:</p> <p>Resident #75 was admitted to the facility from the hospital on [REDACTED]/13 with multiple medically disabling conditions.</p> <p>Resident #75's admission Minimum Data Set (MDS), an assessment tool, dated 10/15/13, indicated the resident was alert, oriented, and able to make him/herself understood. The MDS indicated the resident wore corrective lenses and was able to read regular print.</p> <p>On 11/6/13 at 12:30 p.m., Resident #75 reported that on 11/4/13, after the survey team entered the facility, a nurse removed the resident's [REDACTED] eye drops from the top of resident's bedside table. The resident stated s/he always kept the</p>	F 176	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.</i></p> <hr/> <p>F176</p> <ol style="list-style-type: none"> 1. Resident #75 was assessed for the ability to self-administer his eye drops and other medications. He received education on what the eye drops are for, how to use them, and how to store them. He received a locked box to keep them at the bedside. A medication administration record was provided to him and the nurses are documenting his self-administration. His care plan was revised to reflect the self-administration plan. 2. Residents residing in the facility were reviewed for self-administration of medications. No other residents desired to self-administer medications. 3. The interdisciplinary team and licensed nurses were inserviced on the policy and procedure for self-administration of medications. An audit tool was developed for use upon admission of new patients/residents that identifies people who desire to self-administer medications. The IDT 	12/31/2013

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F 176	<p>Continued From page 2</p> <p>eye drops on top of the table and had been self-administering the drops, but due to "being busy with therapy and everything" at the facility, the resident had not been consistently taking them every day.</p> <p>Resident #75 said the doctor ordered the drops to be taken twice daily. Since being admitted to the facility, the resident was not sure how often s/he was taking the drops. Resident #75 stated that after the nurse took the drops away, the resident had only received them once daily in the evening instead of twice daily as ordered. The resident stated that staff said there were no orders for the eye drops.</p> <p>Resident #75 stated s/he did not tell the facility admission nurse or the hospital staff that the resident had [REDACTED].</p> <p>At 12:35 p.m., when asked, Staff E stated that on 11/4/13, after the survey team entered the facility, s/he took Resident #75's eye drops from the resident's room and put them in the medication room. Staff E said that, until 11/4, s/he did not know the resident had eye drops at the bedside and did not know the resident had [REDACTED].</p> <p>At 12:40 a.m., review of Resident #75's medical record revealed that [REDACTED] was not identified among the resident's diagnoses in the facility record or in the hospital discharge records and transfer orders.</p> <p>At 12:58 p.m., Staff E was observed in his/her office reading the labels on Resident #75's eye drops and writing orders for the eye drops based on the labels. Staff E said, "I just called the ARNP [Advanced Registered Nurse Practitioner]</p>	F 176	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.</i></p> <hr/> <p>then assesses and reviews the patient/resident's ability for self-administration and revises the care plan.</p> <p>4. The Director of Nurses is responsible to monitor this process. The DNS or her designee will audit this process monthly x 3 mos. And as needed thereafter. The DNS will report problems to the PI committee for review and resolution.</p>	12/31/13
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F 176

Continued From page 3
and she said I could add the eye drops to the orders." The staff, not the resident, would administer the eye drops.

Resident #75 was not assessed or care planned for self-administration.

At 1:20 p.m., Staff B said when medications were found at the resident's bedside, the physician should have been notified as soon as possible and an order obtained as appropriate. Staff B said medications brought from home should not be given without an order.

On 11/6/13 at 2:23 p.m., Staff JJ stated that on the evening of 11/4 or 11/5/13, Resident #75 said his/her eye drops had been locked up in the medication room and were in a bag on the counter. The resident told Staff JJ that s/he usually self-administered the drops and asked Staff JJ to bring them. Staff JJ brought the eye drops to the bedside and observed Resident #75 self-administer the medication. Staff JJ said this may have occurred on 11/4 or 11/5 or both.

Staff JJ said the eye drops were not listed on Resident #75's medication administration record and s/he did not document administration of the medication. Staff JJ said, "I assumed there was an order for self-administration. I should have checked for an order."

The facility failed to determine that self-administration of a medication was a safe practice for Resident #75 on 11/4 and/or 11/5/13 when Staff JJ observed the resident self-administer eye drops for [REDACTED] without a physician order for the medication, or an assessment or care plan for self-administration.

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F 176	Continued From page 4 This failure placed the resident at risk for unsafe administration of the medication. Refer to F281.	F 176	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.</i>	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide care and services in a manner that promoted and protected resident dignity and individuality for 2 of 38 sampled residents (#s 93 & 137) reviewed for care and services when facility staff used the bathroom in the shower room during resident showers. This failure placed residents at risk for feelings of embarrassment, loss of dignity and diminished quality of life. Findings include: On 11/5/13 at 10:05 a.m., Resident #93 reported that often, while receiving assistance with showers in the shower room, staff, other than the shower aide, came in and out of the room during the shower. The resident said staff sometimes came in to get something or drop something off. They also came in to use the bathroom inside the	F 241	F241 Privacy curtains are and have been in place for each shower stall to provide patient privacy during personal care. 1. Resident #93 was assessed for psychological harm from the invasion of privacy while taking a shower. She was monitored for 72 hours by nursing and social services and her care plan was updated to reflect this issue. Resident #137 was also assessed for psychological harm from the invasion of privacy while taking a shower. He was monitored for 72 hours by nursing and social services and his care plan was updated to reflect this issue. 2. Residents residing in the facility and who are interviewable were questioned about whether their privacy has been invaded during personal care. Two additional residents were identified and they received psychosocial support and their care plans were updated to reflect the issue. 3. Staff working in every department were inserviced on privacy and dignity during personal care and treatments. Education included	12/31/13

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F 241	<p>Continued From page 5 shower room.</p> <p>Resident #93 stated the shower aide doesn't close the shower stall curtain and the resident is at least partially exposed to other staff coming and going. The resident said s/he didn't like it but accepted it because s/he assumed it was the only bathroom available for staff.</p> <p>On 11/8/13 at 1:45 p.m., accompanied by Staff Q, the west wing shower room was observed: a large open space with 3 wheelchair accessible stalls, a wheelchair accessible scale, a bathtub and a closed door leading to a bathroom with a toilet and sink. There were no curtains or other visual barriers separating shower stalls from the shower room entrance, bathroom entrance, bathtub or wheelchair scale.</p> <p>Staff Q was a shower aide on the west wing and confirmed that other staff often used the bathroom in the shower room while Staff Q was giving showers to residents. Staff Q referred to the bathroom as "the staff bathroom." Staff Q said the facility had 2 shower rooms: one on the west wing and one on the east wing.</p> <p>At 2:00 p.m., Staff FF stated staff regularly used the bathroom in the shower room and that s/he had used the bathroom while residents were being showered.</p> <p>At 2:26 p.m., accompanied by Staff HH, the east wing shower room was almost identical to the west wing shower room: a large open space with 3 wheelchair accessible shower stalls, a wheelchair accessible scale, a bathtub and a closed door leading to a bathroom with a toilet and sink. There were no curtains or other visual</p>	F 241	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.</i></p> <hr/> <p>providing full privacy to residents during care and not utilizing patient care areas for personal use.</p> <p>4. The Executive Director is responsible for monitoring this process. Audits and random interviews with residents will occur weekly x 4 weeks, bi-monthly x 2, and then monthly x 1 month. Audits will be reviewed in PI for three months and as needed thereafter.</p>	12/31/13
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F 241	<p>Continued From page 6</p> <p>barriers separating the shower stalls from the shower room entrance, bathroom entrance, bathtub or wheelchair scale.</p> <p>Staff HH stated that other staff, including the unit nurse manager, often used the bathroom while Staff HH was giving showers to residents. Staff HH disagreed with the practice: "It's a privacy thing. A lot of people don't knock, even during a resident shower. And they bring residents in to be weighed while other residents are getting showers. One aide brought a male resident in for a weight during a female shower." Staff HH said multiple residents expressed discomfort about staff coming in and out during showers.</p> <p>At 2:40 p.m., Staff GG was observed walking out of the west wing shower room and stated s/he had gone in to use the bathroom. No shower was in progress at the time but Staff GG said s/he had occasionally used the bathroom during a resident shower.</p> <p>At 2:57 p.m., Staff A said facility staff should not use the bathrooms in resident shower rooms; staff should use the bathroom in the staff lounge or the ones near the front lobby.</p> <p>On 11/12/13 at 2:17 p.m., Resident #137 said staff often come into the shower room to use the bathroom while s/he is receiving a shower. Resident #137 said, "The shower aide usually pulls the curtain when other staff come in but I still don't like it, especially when women staff come in."</p> <p>The facility failed to promote and protect residents' dignity and individuality when facility staff used the bathroom in the shower rooms</p>	F 241		12/31/13
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F 241	Continued From page 7 during resident showers. This failure placed residents at risk for feelings of embarrassment, loss of dignity and diminished quality of life.	F 241	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
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</p>	F 272	<p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.</i></p> <p>F272</p> <p>1. Resident #30 received an oral examination by an RN. The assessments for 5/28, 8/15, and the current November assessment were corrected to accurately reflect her oral and dental status. She was assessed by the RD to ensure good nutritional status given her oral/dental condition. The social services director met with the resident and she agreed to a treatment plan and dental appointment. The resident later refused the dental care and treatment plan. The social worker provided education about the risks of not receiving treatment for her oral/dental condition. The care plan has been updated to reflect this information and direct staff to properly care for the resident's remaining teeth and gums. The physician was made aware of her oral/dental condition. Resident #23 has been accurately assessed for his hearing impairment and received treatment to remove wax from his ears. Due to a decline in condition, resident #23's guardian</p>	12/31/13

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F 272	<p>Continued From page 8 Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that facility failed to perform thorough comprehensive assessments to identify resident needs for 2 of 38 current sampled residents (#'s 30 & 28) reviewed for dental and hearing. This failure placed residents at risk for decline in medical conditions by not identify the problems, substandard quality of care, quality of life and pain.</p> <p>Findings Include:</p> <p><DENTAL STATUS AND SERVICES> 1. Resident # 30 was initially admitted to the facility on [REDACTED]/12 with diagnosis of [REDACTED], and [REDACTED].</p> <p>On 11/6/13 at 10:46 a.m. Resident # 30 reported only having two teeth.</p> <p>Resident # 30 was observed during interview to have only two teeth in the front, one on each side with decay and inflamed gums.</p> <p>An annual Minimum Data Set (MDS) dated 12/11/12 identified Resident # 30 having obvious or likely cavity or broken natural teeth as well as inflamed or bleeding gums.</p>	F 272	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.</i></p> <hr/> <p>has decided not to pursue further treatment for the impairment. The care plan was updated to reflect this decision and techniques for the staff to improve the resident's ability to communicate effectively.</p> <ol style="list-style-type: none"> Residents residing in the facility were assessed for oral/dental condition. Care plans were revised and updated accordingly. Residents with hearing impairments were identified. Care plans were revised and updated accordingly. Nursing staff in all departments were inserviced on oral, vision, and hearing assessment. Training included documentation, care planning, and necessary referrals for treatment and follow up of problems. The social service department implemented a system of tracking identified needs for dental, vision, and hearing problems. The Director of Nursing is responsible for monitoring this process. This system will be audited by the DNS or her designee weekly x 4 weeks, bimonthly x 2, and monthly x 1. The DNS will provide a report to the PI committee 	12/31/13

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB CENTER- LAKEWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 11411 BRIDGEPORT WAY TACOMA, WA 98499
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F 272	<p>Continued From page 9</p> <p>Resident # 30's care plan dated 4/18/13 did not document any dental status focus or activities of daily living in regards to dental/ oral hygiene.</p> <p>The quarterly MDS dated 5/28/13 did not identify obvious or likely cavity or broken natural teeth.</p> <p>The quarterly MDS dated 8/15/13 did not identify any dental issues.</p> <p>Dental appointments were made for Resident # 30 for the dates of 7/1/13 and 9/27/13 but were declined by the resident.</p> <p>The annual MDS dated 11/1/13 13 did not identify any dental issues.</p> <p>On 11/8/13 at 1:58 p.m. Staff F reported that Resident # 30 did not have all teeth, a broken tooth in front and many teeth missing.</p> <p>On 11/8/13 at 2:03 p.m. Staff D reported that Resident # 30 had missing teeth and that the facility was aware.</p> <p>On 11/8/13 at 2:09 p.m. Staff W reported that Resident # 30 had missing teeth in front and decay along gum line. Staff W reported that Resident # 30 was independent with oral hygiene, but needed assistance with set up.</p> <p>On 11/8/13 at 2:10 p.m. Staff V reported that the information for dental on Resident # 30's previous MDS dated 8/15/13 was used for the annual MDS dated 11/1/13. Staff V reported that the dental problems were not coded due to thinking they were old issues with Resident # 30's teeth. Staff V confirmed Resident # 30 having missing and broken teeth, as well as decay. Staff V reported</p>	F 272	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.</i></p> <hr/> <p>x 3 months and as needed thereafter for problems or concerns with this process.</p>	12/31/13

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F 272 Continued From page 10
that Resident # 30's annual MDS dated 11/1/13 would be amended to document Resident # 30's dental issues.
Failure to conduct an accurate and comprehensive assessment to identify dental problems placed the resident at risk for not receiving the necessary care and services required for oral care.

<VISION AND HEARING>

Resident #28 was admitted on [REDACTED]/13, along with a re-admission after hospitalization on [REDACTED]/13 with diagnoses including [REDACTED], [REDACTED], [REDACTED], and [REDACTED].

Quarterly MDS dated 9/9/13 indicated that Resident #28 used a hearing appliance, was able to speak clearly with distinct intelligible words, was able to understand others and able to make himself understood by others.

On 11/04/2013 02:59 p.m. during resident interview, Resident #28 was unable to hear interview questions asked. Staff J attempted to facilitate resident interview although Resident #28 could not hear her either. When asked how Staff J communicated with Resident #28, Staff J stated that you could write the questions on a notepad. However, when attempted to communicate with Resident #28 by writing on notepad, Resident #28 was unable to read large print measuring one to one and half inches.

On 11/13/13 at 11:20 a.m., Staff F confirmed that Resident # 28's hearing amplification appliance labeled "Stereo Amplified Listener" was not functioning due to eroded batteries.

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F 272	<p>Continued From page 11</p> <p>On 11/13/13 at 11:20 a.m., when asked how Resident #28 communicated with staff, Staff F stated that Resident #28 used a communication book. When attempted to demonstrate, Resident #28 was unable to read print or see pictures in communication book. Staff F confirmed that Resident #28 was unable to see print or pictures in communication book and stated that possibly Resident #28 may need larger print.</p> <p>On 11/13/13 at 11:20 a.m., Staff F was unable to understand Resident #28's speech as he attempted to demonstrate how he communicated with the communication book. Resident #28's speech was slurred and words were unintelligible. Staff F confirmed this.</p> <p>MDS dated 9/9/13 indicated that Resident #28 used a hearing appliance, was able to speak clearly with distinct intelligible words, was able to understand others and able to make himself understood by others. While attempting to interview Resident #28, it was determined that his speech was slurred and unintelligible, he was unable to hear when others spoke clearly, and he was unable to understand others or make himself understood, which is contrary to data in the MDS assessment.</p> <p>Failure to accurately assess resulted in Resident #28's inability to communicate with others, placing him/her at risk for not receiving care and services.</p>	F 272	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.</i></p>	
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279	<p>F279</p> <p>1. The care plan for resident #49 was revised to reflect the [REDACTED]</p>	12/31/13

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F 279

Continued From page 12

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

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.

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).

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, it was determined that the facility failed to develop comprehensive care plans for 2 of 38 current sampled residents (#'s 49, 11 & 39) reviewed for urostomy care, urinary incontinence and activities of daily living. This failure places the residents at risk for receiving substandard quality of care and services to meet the individual needs.

Findings Include:
<UROSTOMY>

Resident #49 was admitted to facility on [redacted]/12

F 279

This Plan of Correction is the center's credible allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.

The care plan for resident #11 was updated to reflect current pertinent issues and care area concerns. The care plan and care directive (Interim Care Plan) for resident #39 were revised to reflect the correct care needs to achieve oral health.

- Residents residing in the facility were reassessed and care plans updated to reflect their current pertinent issues and care area concerns.
- Licensed nurses were inserviced on assessment and care planning. An interdisciplinary team process was developed to review resident assessments and care plans upon admission, quarterly, and with change of condition.
- The Director of Nursing is responsible to monitor this process. The DNS will review this process with the PI committee monthly x 3 months and as needed thereafter when problems arise for review and resolution.

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F 279	<p>Continued From page 13 with the diagnosis of [REDACTED] and [REDACTED] insufficiency.</p> <p>Quarterly MDS dated 9/26/13 identified Resident #49 having a [REDACTED]</p> <p>Care plan dated 6/1/12 with the focus of [REDACTED] care for Resident #49's listed two goals and three interventions.</p> <p>The goals listed on the care plan dated 6/1/13 were for Resident #49 remain free from catheter trauma and for Resident #49 not to develop any complications associated with catheter use.</p> <p>The interventions for the goals were to monitor Resident # 49 for signs and symptoms of discomfort on urination and frequency, to monitor/ document for pain/discomfort due to catheter, and to administer/ monitor the effectiveness of medications as ordered.</p> <p>These goals and interventions pertained to care for a Foley catheter not a urostomy.</p> <p>On 11/12/13 at 11:40 a.m. Staff D confirmed that the goals and interventions on the care plan for Resident #49's care plan were not pertinent to the focus of the urostomy care.</p> <p>On 11/12/13 at 12:15 p.m. Staff C was shown urostomy care plan for Resident #49 and reported that care plans needed to be updated. Staff C confirmed that Resident # 49's care plan was inaccurate for the focus of a urostomy.</p> <p><URINARY INCONTINENCE></p>	F 279		12/31/13

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F 279	<p>Continued From page 14</p> <p>Resident # 11 was re-admitted after hospitalization on [REDACTED]/13 with diagnosis of [REDACTED], [REDACTED], [REDACTED], [REDACTED], general [REDACTED], [REDACTED] ([REDACTED] pain), [REDACTED] (inflammation of [REDACTED]), and history of other [REDACTED] disorders.</p> <p>Quarterly MDS dated 10/10/13 identified Resident # 11's activities of daily living (ADL) status as needing extensive assistance for dressing, toilet use, and bed mobility. On person physical assist with bed mobility and two people physical assist with dressing and toilet use. The MDS identified Resident # 11 as always incontinent of bladder and frequently incontinent of bowel, but no use of a Foley catheter.</p> <p>The care area assessment (CAA) from the original admission MDS dated 2/22/13 identified triggered care areas as cognitive loss, visual function, urinary incontinence, dehydration, dental care, falls, nutritional status, pressure ulcer, psychotropic drug use, and pain.</p> <p>The care plan, dated 3/5/13, (in computer) identified Foley catheter care and dehydration had not been reviewed or updated to reflect current status. Resident #11 no longer had a Foley catheter and was not taking diuretics.</p> <p>A focus of activities of daily living self-care performance deficit care plan was the deficit related to pain. The goals and interventions to follow the focus were not pertinent to current resident issues and care area concerns. This deficit was not assessed when Resident #11 was readmitted in [REDACTED] 2013.</p>	F 279		12/31/13

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F 279	<p>Continued From page 15</p> <p>On 11/7/13 at 1:24 p.m. Staff D confirmed that the care plans had not been updated. Staff D confirmed that the care plan in the computer for Resident # 11 was overdue for being revised. Staff D reported that the care plans are not specific to the resident's current situations and care needs.</p> <p>On 11/8/13 at 11:31 a.m. Staff C reported that care plans should be reviewed by resident care managers (RCM) and updated upon readmission and quarterly.</p> <p><ACTIVITIES OF DAILY LIVING></p> <p>Resident #39 was admitted on [REDACTED]/13 with diagnoses including [REDACTED] disease, [REDACTED] with [REDACTED] disturbance, [REDACTED] and [REDACTED].</p> <p>MDS dated 9/2/13 indicated that Resident #39 required one to two person physical assist with brushing teeth, although Care Plan revised on 7/19/13 had neither mentioned of oral care or level of assistance that Resident #39 required to brush teeth. Additionally the "Interim Care Plan" indicated that Resident #39 was independent for mouth care.</p> <p>On 11/05/2013 10:37 a.m., Resident #39 had foul mouth odor along with whitish yellow plaque that turned to grayish color as it progressed up tooth surface. Staff D confirmed that Resident #39 had foul mouth odor and visible plaque on lower teeth.</p> <p>When showed the "Interim Plan of Care" that indicated that Resident #39 was independent for mouth care, Staff D stated that s/he would need to change the care plan to include additional</p>	F 279		12/31/13
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F 279	<p>Continued From page 16</p> <p>assistance for oral hygiene. Furthermore, Staff D confirmed that the facility's "Interim Care Plan" was the method of communication that NAC's utilized to direct and guide the care they provided to residents in the facility.</p> <p>11/12/13 at 2:05 p.m., Resident #39's [REDACTED] stated that her only concern about the facility was that her [REDACTED] teeth have been pretty dirty.</p> <p>On 11/05/2013 10:37 a.m., Resident #39 stated that he brushed his own teeth but when asked to demonstrate oral hygiene he was unable to find toothbrush or toothpaste and subsequently gave up trying to brush his teeth.</p> <p>On 11/05/2013 12:27 p.m., during oral hygiene observation for Resident #39, Staff Y was unable to find a tooth brush for Resident #39. Once a new toothbrush was obtained from facility supply room, Staff Y provided Resident #39 with set up as Resident #39 was unable to set up oral hygiene independently. Resident #39 then brushed his top front teeth lightly however he neglected molar surfaces and lower front teeth. Resident #39 required extensive cueing and encouragement along with total assistance in order to properly brush his teeth and remove plaque from all surfaces of his teeth.</p> <p>Although MDS dated 9/2/13 indicated that Resident #39 required physical assist with brushing his teeth, the Care Plan revised on 7/19/13 had no indication of any oral hygiene requirements. Furthermore, the "Interim Care Plan" indicated that Resident #39 was independent for mouth care. As a result, there was no consistency in documentation for assistance required for Resident #39 to perform</p>	F 279		12/31/13

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F 279	Continued From page 17 proper oral hygiene.	F 279	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
F 281 SS=E	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, it was determined the facility failed to ensure nursing services met professional standards of quality for 3 of 38 sample residents (#s 163, 93 & 75) when 1) Resident #163 missed 2 consecutive doses of [REDACTED] antibiotic; 2) the dressing for Resident #93's stage I pressure ulcer was not changed for 6 days when it was ordered 3 times per week; and 3) Resident #75 self-administered eye drops for [REDACTED] without an order for the medication or an assessment or care plan for self-administration. These failures placed Resident #163 at risk for delayed recovery from a [REDACTED] infection; placed Resident #93 at risk of delayed healing or decline in condition of a current [REDACTED]; and placed Resident #75 at risk for unsafe administration of medication.</p> <p>Findings include:</p> <p>According to Smith, Duell and Martin, Clinical Nursing Skills, Sixth Edition, pages 518-521, nurses are to administer medications as ordered by the physician.</p>	F 281	<p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.</i></p> <p>F281</p> <ol style="list-style-type: none"> The physician for resident #163 was notified of the two missed doses of antibiotic. The resident was assessed for any worsening condition. The dressing change for resident #93 receives dressing changes at the wound care clinic. The treatment administration record now clearly reflects when the nurses are to change the dressing on the required days each week. The wound was assessed for any worsening condition and the care plan updated to reflect wound care needs. The physician for resident #75 was notified and he was assessed for a self-medication administration program. His care plan was revised to reflect his current self administration of medication program. Medication administration records were reviewed for residents residing in the facility for missed doses. No other missed doses of medication were found. Treatment administration records were reviewed for residents residing in the facility for missed treatments. 	12/31/13

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F 281	<p>Continued From page 18</p> <p>According to Fundamentals of Nursing, 7th Edition (Taylor, Lillis, LeMone & Lynn), page 125, "Nurses are legally responsible for carrying out the orders of the physician in charge of a patient"</p> <p>RESIDENT #163</p> <p>Resident #163 was admitted to the facility on [REDACTED]/13 for administration of [REDACTED] after being hospitalized and admitted with acute [REDACTED] failure, [REDACTED] ([REDACTED]) [REDACTED] and acute [REDACTED] [REDACTED]</p> <p>Physician orders for Resident #163 included [REDACTED] (antibiotic) [REDACTED] milligrams every 6 hours with a stop date of [REDACTED]/13.</p> <p>On 11/13/13 at 8:10 a.m., Resident #163 stated that on 11/9/13 at 11:00 p.m., when a dose of the antibiotic was due, Staff U informed the resident there were no doses available. The resident stated s/he missed 2 consecutive doses of the medication and was very concerned about the potential negative effect on his/her recovery from the infection.</p> <p>Review of Resident #163's Medication Record (MR) revealed the antibiotic was scheduled at 5:00 a.m., 11:00 a.m., 5:00 p.m., and 11:00 p.m. The doses on 11/8/13 at 11:00 p.m. and 11/9/13 at 5:00 a.m. were marked "NA." The Nurse's Medication Notes, signed by Staff U, indicated the doses were missed because the medication was "not available." Staff U documented s/he called the pharmacy and the medication would arrive on the morning of 11/9/13.</p>	F 281	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.</i></p> <hr/> <p>Residents requiring wound care are receiving the ordered treatments and monitoring. Residents residing in the facility were reviewed for the potential of self-administering medications. No other residents are self-administering medications at this time.</p> <ol style="list-style-type: none"> Licensed nurses were inserviced on the proper procedure to order medications from the pharmacy and what to do if medications are missing. Licensed nurse inservicing occurred on the facility protocol for wound and skin care, and self-administration of medications. The DNS or designee will perform regular audits of the medication and treatment records for missing doses and treatments. There is an interdisciplinary process for assessment and care planning of residents who wish to self-administer medications. The DNS will audit the process for self-administration of medications monthly. The DNS is responsible to monitor these processes. The DNS will report to the PI committee x 3 months and as 	12/31/13

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F 281	<p>Continued From page 19</p> <p>At 9:03 a.m., Staff U stated that on 11/8/13 at 10:45 p.m., s/he discovered the box in the medication room for storing Resident #163's [REDACTED] was empty. Staff U searched the medication room but no doses of the antibiotic were found.</p> <p>Staff U called the pharmacy and was told a refill of the medication had not been ordered. Staff U verbally requested the medication be sent as soon as possible and sent a refill order by facsimile at 11:11 p.m.</p> <p>Staff U stated s/he did not notify the physician of the 2 missed doses of [REDACTED] and did not know if any other staff reported it.</p> <p>The MR indicated the next dose of [REDACTED] was administered on 11/9/13 at 11:00 a.m., 12 hours late and 18 hours after the previous dose on 11/8/13 at 5:00 p.m.</p> <p>On 11/13/13 at 11:51 a.m., Staff C stated the facility procedure for generating pharmacy refill orders for IV antibiotics was that medication nurses were to send pharmacy refill orders by facsimile when only 3 or 4 doses were left in the resident's supply. Staff C confirmed there was no refill order for Resident #163's [REDACTED] before the order sent by Staff U on 11/8/13.</p> <p>The failure to ensure the antibiotic was available as ordered placed the Resident #163 at risk for diminished effectiveness of the antibiotic and delayed recovery from a life-threatening [REDACTED] infection.</p> <p>Refer to F333.</p>	F 281	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.</i></p> <hr/> <p>needed thereafter if problems arise with these processes.</p>	12/31/13

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F 281	<p>Continued From page 20</p> <p>RESIDENT #93</p> <p>Resident #93 was admitted to the facility from the hospital on [REDACTED]/13 with diagnoses to include [REDACTED], chronic [REDACTED] and an infected stage 4 [REDACTED] on the [REDACTED] with [REDACTED] ([REDACTED] tissue).</p> <p>The Minimum Data Set (MDS), an assessment tool, dated 9/26/13, indicated Resident #93 was alert, oriented and able to make his/her needs known and required extensive assistance of two persons with transfers and bed mobility. No behaviors of rejection or resistance to care were identified.</p> <p>The physician's order, dated 9/28/13, instructed staff to cleanse Resident #93's [REDACTED] heel with normal saline daily, apply a alginate (wound treatment), cover and wrap with gauze and change daily.</p> <p>Dressing changes were documented on the Treatment Record (TR). Resident #93's TR indicated dressing changes were done daily. The TR did not document wound assessments.</p> <p>The "Daily Monitoring/Pressure Ulcers" form for October 2013 provided spaces for daily wound assessment, including wound status, dressing condition, surrounding skin, wound edges and associated pain. The form reflected documentation for only 7 days: October 1, 2, 3, 5, 6, 7, and 17.</p> <p>The physician's order, dated 10/31/13, instructed facility staff to administer Negative Pressure Wound Therapy (NPWT) to the pressure ulcer on</p>	F 281		12/31/13

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F 281	<p>Continued From page 21</p> <p>Resident #93's heel and to change the dressing 3 times per week and as needed.</p> <p>According to the facility's policy, dated 4/28/13, NPWT removes infectious material from the wound with sub-atmospheric pressure (suction) to promote healing in wounds which have failed to proceed through normal stages of healing with standard treatment. (NPWT is also referred to as a "wound vac.")</p> <p>Resident #93's November TR instructed staff to cleanse the heel wound and change the wound vac dressing 3 times per week, and as needed. Specific days of the week for the dressing changes were not identified.</p> <p>On Thursday, 11/7/13 at 9:15 a.m., review of interventions listed on Resident #93's care plan for the heel pressure ulcer did not include the wound vac.</p> <p>At 9:20 a.m., when advised that the surveyor would need to observe the dressing change to Resident #93's heel, Staff L said the dressing was done the previous day at the wound clinic and wasn't due again until Friday.</p> <p>Staff L said wound assessments were documented on the TR. The surveyor and Staff L reviewed the November TR and noted there was only one assessment of the heel wound, on 11/5/13: "L heel wound measurements cm (centimeters) x cm x cm." There was no documentation on the TR indicating daily monitoring of the dressing.</p> <p>At 10:24 p.m., Staff E said pressure ulcers were documented on the "Weekly Pressure Ulcer</p>	F 281		12/31/13

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F 281	<p>Continued From page 22</p> <p>BWAT Report" (BWAT). The surveyor was able to locate only two BWATs, dated 9/19/13 and 10/3/13, for Resident #93's heel ulcer. Staff E was unable to locate additional BWATs for the wound, daily monitoring of the dressing or any documentation of weekly wound assessments and treatments administered at the wound clinic.</p> <p>At 1:14 p.m. at the surveyor's request by phone, the wound clinic sent by facsimile documents reflecting weekly assessments and treatments of Resident #93's heel wound. The records indicted the size of the wound was diminishing. On 9/25/13 the wound measured x cm (centimeters). On 11/6/13 it measured by cm and the wound bed was debrided due to a hematoma.</p> <p>On Tuesday, 11/12/13 at 8:15 a.m., Resident #93 stated s/he was "very concerned" that the dressing had not been changed since the last weekly visit to the wound clinic on Wednesday, 11/6/13. The resident stated, "It's supposed to be changed 3 times a week."</p> <p>At 8:30 a.m., when advised that the surveyor would need to observe the dressing change to Resident #93's heel, Staff L stated, "It's not due today. It's due on Monday, Wednesday and Friday."</p> <p>The surveyor and Staff L reviewed the TR and noted the TR did not specify which days the wound change was scheduled and that the dressing had not been changed since six days ago, on 11/6/13 at the wound clinic. Staff L said s/he did not know why the dressing had not been changed on Friday or Monday but s/he was extremely busy and would not have time to</p>	F 281		12/31/13

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F 281 Continued From page 23
change the dressing during his/her shift. Staff L did not indicate a plan to assure the dressing change was completed that day.

At 10:14 a.m., Staff C stated the facility policy was to document pressure ulcer assessments weekly on the BWAT, noting appearance and size of the wound. Staff C said dressings were to be monitored daily and documented on the TR for appearance, drainage and intactness. Staff C said dressing changes should be scheduled on specific days, noted on the care plan and documented on the TR.

Staff C stated s/he would make sure Resident #93's dressing change was done that day and the facility would educate licensed staff regarding treating, monitoring and documenting pressure ulcers.

Refer to F314.

RESIDENT #75

Resident #75 was admitted to the facility from the hospital on [REDACTED]/13 with multiple medically disabling conditions.

Resident #75's admission Minimum Data Set (MDS), an assessment tool, dated 10/15/13, indicated the resident was alert, oriented, and able to make him/herself understood. The MDS indicated the resident wore corrective lenses and was able to read regular print.

On 11/6/13 at 12:30 p.m., Resident #75 reported that on 11/4/13, after the survey team entered the facility, a nurse removed the resident's [REDACTED] eye drops from the top of resident's bedside

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F 281	<p>Continued From page 24</p> <p>table. The resident stated s/he always kept the eye drops on top of the table and had been self-administering the drops, but due to " being busy with therapy and everything" at the facility, the resident had not been consistently taking them every day.</p> <p>Resident #75 said the doctor ordered the drops to be taken twice daily but, since being admitted to the facility, the resident was not sure how often s/he was taking the drops. Resident #75 stated that after the nurse took the drops away, the resident had only received them once daily in the evening instead of twice daily as ordered by his/her physician. The resident stated that staff said there were no orders for the eye drops.</p> <p>At 12:35 p.m., when asked, Staff E stated that on 11/4/13, after the survey team entered the facility, s/he took Resident #75's eye drops from the resident's room and put them in the medication room. Staff E said that, until 11/4, s/he did not know the resident had eye drops at the bedside and said there was no documentation to reflect that the medications were removed from the resident's room.</p> <p>At 12:58 p.m., Staff E was observed in his/her office reading the labels on Resident #75's eye drops and writing orders for the eye drops based on the labels.</p> <p>Staff E stated that staff, not the resident, would administer the eye drops. Resident #75 was not assessed or care planned for self-administration.</p> <p>Staff E said, "I just called the ARNP [Advanced Registered Nurse Practitioner] and she said I could add the eye drops to the orders." Staff E</p>	F 281		12/31/13

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F 281	<p>Continued From page 25</p> <p>said s/he would have called the ARNP about the medication sooner but was unable to contact the resident's [REDACTED] for confirmation. When the surveyor pointed out that the resident's [REDACTED] had been at the facility for several hours the previous day Staff E said, "Oh yeah."</p> <p>At 1:20 p.m., Staff B stated the admission nurse was responsible to ask residents about their diagnoses and medical history but when Resident #75 was admitted the resident was in pain and, "[The resident] wasn't in the mood to discuss anything when [s/he] got here."</p> <p>Staff B said when medications were found at the resident's bedside, the physician should have been notified as soon as possible and an order obtained as appropriate. Staff B said medications brought from home should not be given without an order.</p> <p>On 11/6/13 at 2:23 p.m., Staff stated s/he brought the eye drops to the bedside and observed Resident #75 self-administer the medication. Staff JJ said this may have occurred on 11/4 or 11/5 or both. Staff JJ said s/he did not check the expiration date.</p> <p>Staff JJ said the eye drops were not listed on Resident #75's medication administration record and s/he did not document administration of the drops. Staff JJ said, "I assumed there was an order for self-administration. I should have checked for an order."</p> <p>The facility failed to determine that self-administration of a medication was a safe practice for Resident #75 on 11/4 and/or 11/5/13 when Staff JJ observed the resident</p>	F 281		12/31/13

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F 281	Continued From page 26 self-administer eye drops for [REDACTED] without an order for the medication or an assessment or care plan for self-administration. This failure placed the resident at risk for unsafe administration of the medication. Refer to F176.	F 281	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.</i>	
F 285 SS=E	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental	F 285	F285 1. Resident #11 received a level II PASRR evaluation on 7/10/2013. Resident #7 is no longer at the facility. Resident # 15 has had a new Level I PASRR completed. Resident # 123 has had a new Level I PASRR completed. Resident #22 has had a new Level I PASRR completed. Resident #57 could not be identified from the sample. Resident #95 has now had a Level I PASRR completed. Residents #99, 27, 68, 135, 132, 130, and 139 no longer reside in the facility. 2. Residents residing in the facility were reviewed for current Level I PASRR. These were completed as needed. Level II PASRR evaluations were requested as needed. 3. The facility has an interdisciplinary process and audit tool for completed Level I PASRR evaluations at time of admission. The admissions coordinator has discussed the need for these evaluations at time of admit with	12/31/13

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F 285	<p>Continued From page 27</p> <p>condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>For purposes of this section:</p> <p>(i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1).</p> <p>(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure Pre-Admission Screening and Resident Review (PASRR) assessments were accurately completed upon, or prior to, admission to the facility for 7 of 38 current sample residents (#s 15, 123, 11, 22, 7, 57 and 95) and 7 of 30 former residents (#s 99, 27, 68, 135, 132, 130 and 139). Failure to ensure PASRR's were done and/or accurately completed, placed residents at risk for inappropriate placement and/or not receiving timely and necessary services to meet their mental health [MH] and/or developmental disability [DD] care needs.</p> <p>Findings include:</p> <p>1) Resident # 11 was admitted from the hospital on [redacted]/13 with multiple medical diagnoses including [redacted] and [redacted]. The hospital PASRR was found by the Social Services Director</p>	F 285	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.</i></p> <hr/> <p>discharge planners. The Social Services Director or her assistant will audit the record for this evaluation at time of admit and complete them timely as needed. Level II PASRR evaluations will be requested timely as needed following admit.</p> <p>4. The Director of Nursing is responsible to monitor this process. The DNS or her designee will complete a monthly audit of PASRR evaluations and report to the PI committee x 3 months and as needed thereafter for problems with this process.</p>	12/31/13
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F 285	<p>Continued From page 28</p> <p>[SSD] dated 2/14/13 but failed to indicate the need for further evaluation [Level II]. The facility completed a PASRR on 5/6/13 and requested further Level II evaluation that was completed 2 months later on 7/10/13.</p> <p>2) Resident # 7 was admitted from the hospital on [REDACTED]/13 with multiple medical diagnoses including [REDACTED]. No PASRR was found in the records to indicate the need for further evaluation.</p> <p>3) Resident #15 was admitted from the hospital on [REDACTED]/13 with multiple medical diagnoses including [REDACTED], [REDACTED], [REDACTED] disease [REDACTED], [REDACTED] failure [REDACTED], [REDACTED] and [REDACTED] disease. The hospital PASRR failed to indicate anxiety and other medical conditions to ensure accuracy of need for further assessment [Level II].</p> <p>4) Resident #123 was admitted from the hospital on [REDACTED]/13 with multiple medical diagnoses including [REDACTED] disorder. No PASRR was found in the records.</p> <p>5) Resident #22 was admitted from the hospital on [REDACTED]/13. No PASRR was found in the records.</p> <p>6) Resident #57 was admitted from the hospital on [REDACTED]/13 with multiple medical diagnoses including [REDACTED]. No PASRR was found in the record.</p> <p>7) Resident #95 was admitted from the hospital on [REDACTED]/13 with diagnoses of [REDACTED], [REDACTED] and [REDACTED] disease. No hospital PASRR was found. On 5/24/13, the PASRR was inaccurately completed by the facility and</p>	F 285		

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB CENTER- LAKEWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 11411 BRIDGEPORT WAY TACOMA, WA 98499
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F 285	<p>Continued From page 29</p> <p>indicated further assessment was required when the resident had diagnoses to indicate further assessment may not be appropriate.</p> <p>8) Former Resident #99 was admitted to facility from the hospital on [REDACTED]/13 with multiple medical diagnoses including [REDACTED] disability [REDACTED], [REDACTED] and [REDACTED]. The hospital PASRR was inaccurately completed and failed to indicate [REDACTED] and [REDACTED] but did identify a [REDACTED] history. No documentation was found to indicate further assessment was done for this resident as required.</p> <p>9) Former Resident #27 was admitted from the hospital on [REDACTED]/13 with multiple medical diagnoses including [REDACTED] failure [REDACTED] disease and [REDACTED]. No PASRR was found in the records. On 11/8/13, the Social Services Director SSD] was unable to find a PASRR.</p> <p>10) Former Resident #68 was admitted from the hospital on [REDACTED]/13 with multiple medical diagnoses including [REDACTED]. Review of the PASRR completed at the hospital was inaccurate and failed to indicate [REDACTED]. Interview with the SSD on 11/8/13 verified the inaccuracy of the PASRR.</p> <p>11) Former Resident #135 was admitted from the hospital on [REDACTED]/13 with multiple medical diagnoses including [REDACTED] and [REDACTED]. No PASRR was completed for this admission.</p> <p>12) Former Resident #132 was admitted from the hospital on [REDACTED]/13 for [REDACTED] and diagnoses of [REDACTED] and [REDACTED]. No PASRR was completed for this admission.</p>	F 285		12/21/13
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F 285 Continued From page 30

13) Former Resident #130 was admitted from hospital on [REDACTED]/13 with multiple medical diagnoses. No hospital PASRR was completed. The facility completed the PASRR on 6/21/13, five days after admission.

14) Former Resident #139 was admitted from the hospital on [REDACTED]/13 with multiple medical diagnoses including [REDACTED] and generalized [REDACTED]. The hospital PASRR was inaccurate and failed to indicate the need for further screening as required.

During interview and review of these Residents' PASRRs with the new Social Services Director on 11/8/13 at noon, she stated she worked closely with the PASRR evaluator and was becoming more familiar with the PASRR process. She stated she would review current residents' PASRRs and new admissions for completion and accuracy of PASRRs and follow up as necessary.

F 285

This Plan of Correction is the center's credible allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.

F 309 SS=D 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:

F 309

- F309
1. Resident #11 was assessed for pain and her physician was notified. The care plan was updated to accurately reflect her pain and limitations related to pain.
 2. Residents residing in the facility were reviewed for current pain assessment and care plan updates.
 3. Licensed nurses and skilled therapy staff were inserviced regarding pain, pain assessment and documentation, interventions to treat pain, and timely notification of pain. The interdisciplinary team reviews residents with unresolved pain to develop a treatment plan.

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F 309

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Based on observation, interview, and record review it was determined that the facility failed to provide the necessary care and services to assess and treat pain for 1 of 1 sampled residents (#11) reviewed for pain when the resident ' s pain was not managed so as to allow the resident to fully participate in therapies. This failure placed the resident at risk for untreated pain, a decline in mobility, function, and quality of life due to restrictions caused by pain.

Findings Include:

Resident #11 initially admitted on [REDACTED]/13 and was re-admitted after hospitalization on [REDACTED]/13 with diagnosis of [REDACTED], general [REDACTED] [REDACTED] pain), [REDACTED] (inflammation of [REDACTED]), and history of other [REDACTED] disorders.

A quarterly minimum data set (MDS) dated 10/10/13 identified Resident #11 as cognitively intact. For activities of daily living (ADL) Resident #11 was identified as needing extensive assistance for dressing, toilet use, and bed mobility. The resident needed two staff person physical assistance for bed mobility and one staff for dressing and toileting.

"Physical Therapy (PT) Evaluation," dated 7/17/13, documented for Resident #11 to receive skilled PT for therapy evaluation, therapeutic activities, and gait training. A pain assessment, dated 7/17/13, was completed on evaluation and identified Resident #11 had pain at a scale of [REDACTED] during activity on a 0-10 pain scale. Location of pain was documented to be in Resident #11's low [REDACTED], [REDACTED], and [REDACTED].

F 309

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4. The Director of Nurses is responsible to monitor this process. Monthly review of the pain flowsheet and daily pain assessments will be completed by the DNS or her designee. A report to the PI committee on this system will be made by the DNS monthly x 3 months and as needed thereafter.

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F 309	<p>Continued From page 32</p> <p>"Physical therapy evaluation," dated 7/17/13, documented "additional medical diagnosis impacting PT included [redacted], [redacted] and [redacted] pain and [redacted]." The patient /family goal documented was "to be more mobile."</p> <p>"Physical Therapy Progress Report" from 7/25/13 to 7/31/13 documented that Resident #11 "made slow and steady progress this past week in spite of refusing to get out of bed or go to rehab gym twice." Standing/ ambulation limited some days by knee pain." Knee pain was documented as a barrier to improvement. Potential for achieving goals was documented as good and that diathermy (electronically induced heat) would be included for knee pain.</p> <p>A "Physical Therapy Discharge Summary," dated 8/6/13, documented PT was discontinued on 8/2/13. The comparative statement documented that Resident #11 "hasn 't made significant progress since last progress note, as resident refuses to get out of bed." Discharge Summary for PT documented that Resident #11 was having pain in knees at a [redacted] out of 10 on a 0 to 10 pain scale and that electronic stimulation helped to decrease pain. It was documented that resident goals were not met due to resident refusing to get out of bed.</p> <p>Resident #11's record did not contain evidence that staff reassessed why he/she was refusing PT and/ or if and how pain was being managed and how it impacted the ability to participate during PT.</p> <p>On [redacted]/13 at 9:56 a.m., Staff I reported that Resident #11 was discharged from PT due to</p>	F 309		12/31/13
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F 309	<p>Continued From page 33</p> <p>refusing and not wanting to get out of bed. Staff I reported that after refusing a few times the resident was discharged from PT.</p> <p>On 11/7/13 at 10:23 a.m., Resident #11 reported being on PT but not wanting it any longer. Resident # 11 reported having a lot of pain, mostly in knees but also in hips. The pain was worse on the [redacted] side.</p> <p>Resident #11's initial admission care plan, dated 2/15/13, for the focus of chronic [redacted] and [redacted] pain related to [redacted] had not been updated since the original admission date and the interventions in place were not reassessed or revised to ensure that the resident was getting adequate pain management.</p> <p>On 11/8/13 at 9:22 a.m., Resident # 11 reported having pain in hips and knees for a long time. Resident #11 reported that the [redacted] (pain medication) helps for about four hours but it did not take the pain away completely. Resident #11 reported that being repositioned, sitting up on the side of bed, and that hot showers help with the pain.</p> <p>Resident #11 confirmed that the facility did not offer alternative interventions to relieve pain.</p> <p>Resident #11 reported that the reason for refusing PT was due to pain and not being able to get the assistance needed to get back in bed after PT.</p> <p>On 11/8/13 at 12:01 p.m. Staff C reported that the resident's care plans should be updated when returning from the hospital, with any changes and with each MDS.</p>	F 309		12/31/13

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F 309	<p>Continued From page 34</p> <p>On 11/8/13 at 3:30 p.m. Staff C reported that he/she spoke with Resident #11 and the resident reported that pain was the reason he/she did not want to get out of bed. NO documentation was found to verify this occurred.</p> <p>Failure to re-assess, monitor and follow up with Resident #11's pain management resulted in the resident refusing therapy due to the pain. This failure placed the resident at risk for untreated pain, decline in mobility, strength and quality of life.</p> <p>Failure to re-assess and revise Resident #11's care plan since admission on [redacted]/13 placed the resident at risk for decreased quality of care. Without updating the care plan staff is unable to identify how to care for Resident #11's care needs related to pain, and how it impacted the refusal of therapy and ADLs.</p>	F 309	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.</i></p>	
F 312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, it was determined the facility failed to provide necessary care and services to maintain</p>	F 312	<p>F 312</p> <ol style="list-style-type: none"> 1. Resident #104 has thickened nails that cannot be trimmed by regular means. The patient is scheduled to see a health care provider with equipment required to mechanically sand the nails. Resident #39 was assessed for oral health and the care plan and care directive revised to reflect the assistance he requires to brush his teeth. 2. Residents residing in the facility were assessed for nail care and oral/dental health. Care plans and care directives were revised and updated as necessary to reflect each need. Residents with diabetes were 	12/31/13

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 nail care and oral hygiene for residents who are unable to independently carry out activities of daily living (ADLs) for 2 of 4 sample residents reviewed for ADLs (#s 104 & 39). This failure placed residents at risk of dental problems, overgrown fingernails and toenails, infection and diminished quality of life.

Findings include:
 RESIDENT #104

Resident #104 was initially admitted to the facility on [redacted]/13 with diagnoses to include a [redacted] disorder, [redacted] and [redacted]. The resident was readmitted from the hospital on [redacted]/13 and [redacted]/13.

Resident #104's Minimum Data Set (MDS), an assessment tool, dated 10/28/13, indicated the resident had memory problems but was able to make needs known. The MDS indicated the resident was non-ambulatory and was completely dependent on facility staff for extensive assistance with all activities of daily living, including grooming and hygiene.

Resident #104's physician orders included nail care to be done by a licensed nurse on a weekly basis.

Resident #104's Treatment Record (TR) for October and November, 2013, stated, "Nail care is to be done by licensed nurse on a weekly basis." The TR did not indicate a specific day of the week for nail care. The resident's TR documented no nail care for October or November, 2013.

F 312

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identified on their treatment administration record with a scheduled day each week to have nail care performed by a licensed nurse.

- Nursing staff (licensed nurses and certified nursing assistants) were inserviced on the process for providing nail care to diabetic residents. Licensed nurses were inserviced on oral assessment and care planning to reflect the care needs of residents with regard to oral hygiene. Certified nursing assistants received training on performing oral hygiene tasks with residents. Certified nursing assistants were inserviced on informing the licensed nurse if a resident refuses care for activities of daily living such as nail and oral care.
- The Director of Nursing is responsible to monitor these processes. The DNS or her designee will perform monthly audits of nail care, oral hygiene and oral care documentation. The DNS will report on these processes to the PI committee monthly x 3 months and as needed thereafter.

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F 312	<p>Continued From page 36</p> <p>On 11/5/13 at 7:42 p.m., all of Resident #104's fingernails were observed to be approximately ½ inch long. The resident's [REDACTED] stated s/he would like staff to trim the fingernails and the resident agreed. Resident #104 said the shower aide told the resident the aide could not do his/her nail care because the resident had [REDACTED] and it would have to be done by nursing staff.</p> <p>Resident #104 said his/her toenail care was done by a podiatrist.</p> <p>On 11/7/13 at 2:14 p.m., Staff Q, a shower aide, said s/he does nail care for most residents when they have showers, but nursing staff must do all nail care for residents who have diabetes.</p> <p>On 11/7/13 at 2:49 p.m., Staff E, the Resident Care Manager, said it was the responsibility of medication/treatment nurses to perform nail care for residents who have diabetes. Staff E said it should be done on shower day, when nurses perform skin assessments.</p> <p>On 11/7/13 at 2:53 p.m., Staff L, a medication/treatment nurse, said s/he had never done nail care for Resident #104 and could only identify one resident s/he had performed nail care for. Staff L said s/he did not document the nail care and did not routinely assess fingernails and toenails of residents who have [REDACTED]</p> <p>On 11/12/13 at 10:16 a.m., Staff C, the Director of Nursing Services, stated that nursing staff should have clarified a regimen for implementing the order for weekly nail care for Resident #104, such as a specific day of week, and must document when they perform nail care.</p>	F 312		12/31/13

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F 312	<p>Continued From page 37</p> <p>RESIDENT #39</p> <p>Resident admitted to the facility on [REDACTED]/13 with diagnoses including [REDACTED] disease, [REDACTED] with [REDACTED] disturbance, [REDACTED], and [REDACTED].</p> <p>On 11/05/2013 10:37 a.m., Resident # 39 had foul smelling breath and had thick yellowish white plaque along lower front teeth gum line which then progressed to a grayish color. Staff D observed plaque and stated that facility form labeled "Interim Plan of Care" needed to be adjusted to reflect more assistance when performing oral hygiene.</p> <p>On 11/12/13 at 2:05 p.m., Resident # 39's [REDACTED] voiced complaints that her [REDACTED] teeth have been "dirty".</p> <p>On 11/05/2013 10:37 a.m. during resident interview, Resident # 39 stated that he brushed his own teeth but when asked to demonstrate oral hygiene he was unable to find toothbrush or toothpaste and gave up trying to brush his teeth.</p> <p>On 11/05/2013 12:27 p.m., Staff Y stated that she performed Resident # 39's oral hygiene in afternoon if resident is willing. Resident # 39 can be combative and it can be difficult to brush his teeth.</p> <p>During observation on 11/05/2013 12:27 p.m., Staff Y brushed Resident # 39's teeth allowing resident to brush his own teeth at first. Resident # 39 only concentrated his upper teeth and neglected the lower front teeth, back teeth and molar surfaces. Staff Y encouraged Resident #39</p>	F 312		12/31/13

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to brush all surfaces of his teeth. After Resident # 39 received total assistance to perform oral hygiene, Resident #39 lower teeth no longer had debris or plaque. Resident #39 was cooperative and non-combative during oral care.

On 11/05/2013 12:27 p.m., Staff Y stated that when residents refused oral hygiene, nursing assistants should report it to the nurse.

On 11/12/13 at 10.17 a.m., when asked how NAC's communicate refusal of oral care, Staff V stated that NAC's should document refusal of resident care in the facility's "Communication Book". Staff V was unable to locate any documentation of Resident # 39's refusal of care in the "Communication Book". Furthermore, the facility's "Communication Book" was completely empty, void of any documentation sheets.

F 312

This Plan of Correction is the center's credible allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.

F 313 SS=D 483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION

To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, it was determined that the facility failed to

F 313

F 313

1. Resident #28 received care to remove ear wax. The guardian has declined further treatment due to a declining condition. The care plan was revised to reflect the current status of his hearing and communication needs.
2. Residents who reside in the facility were reviewed for hearing and visual impairments requiring further treatment. Appointments were made for follow up as necessary.

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F 313 Continued From page 39
ensure that the resident received proper treatment and assistive devices to maintain hearing ability for 1 of 1 (# 28) reviewed in the Stage 2 sampled review. This failure places the residents at risk for receiving substandard quality of care and diminished quality of life.

Findings Include:

Resident # 28 was admitted on [REDACTED]/13, along with a re-admission after hospitalization on [REDACTED]/13 with diagnoses including [REDACTED], [REDACTED], [REDACTED], and [REDACTED].

11/13/13 at 11:10 a.m., Staff F stated, that back in July 2013, Resident # 28 was receiving [REDACTED] ear drops to loosen ear wax in order to facilitate a visual examination and possibly be fitted for hearing aids from [REDACTED]. This treatment was interrupted due to Resident # 28's illness and subsequent hospitalization in [REDACTED] 2013. Later in September, documentation revealed Resident # 28 had an ear [REDACTED] that was treated with [REDACTED] drops that concluded on 9/26/13.

11/13/13 at 11:10 a.m., Staff F confirmed that there was no follow up to make a new appointment with [REDACTED] after Resident # 28's [REDACTED] 2013 illness stabilized. Also, Staff F confirmed that her only method of communication to keep abreast of residents' changing conditions was word of mouth from the facility nursing staff.

On 11/13/13 at 11:20 a.m., when asked how Resident # 28 communicated with staff, Staff F stated that Resident # 28 used a facility

F 313

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3. A referral system was implemented for nursing staff to communicate hearing and vision needs to the Social Services Department for follow up. The Social Services Department developed a tracking system to ensure that follow up appointments occur. The interdisciplinary team and nursing staff (licensed nurses and certified nursing assistants) were inserviced on the referral system.
4. The Director of Nursing is responsible to monitor this system. The DNS or her designee will perform regular audits of the referral system and the scheduling of follow up appointments. The Social Services Director will report on this process to the PI committee monthly x 3 and as needed thereafter for review and resolution of problems.

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F 313	<p>Continued From page 40</p> <p>developed communication book with larger print and pictures. Resident # 28 was unable to read print or see pictures on communication book. Staff F stated that possibly print needed to be larger on communication book and that Resident # 28 could benefit by an ophthalmology appointment.</p> <p>On 11/13/13 at 11:20 a.m., Resident # 28 confirmed he would like his ear wax flushed so he can be fitted for a hearing aid, and would like an appointment to have his eyes tested. Staff F confirmed this.</p> <p>On 11/13/13 at 11:10 a.m., Staff F confirmed that the facility could have provided follow up after Resident # 28's condition stabilized in providing appointments to possibly correct Resident # 28's visual and hearing impairments.</p>	F 313	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.</i></p>	
F 314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to</p>	F 314	<p>F314</p> <ol style="list-style-type: none"> 1. Resident #93 now receives wound care 3 x per week unless the wound care center performs the dressing change during appointments. Dressing changes are documented in the resident's treatment administration record. The wound is monitored daily per the facility protocol using the Daily Monitor for Pressure Ulcers form. The care plan was updated to accurately reflect the current wound treatment. The weekly wound assessment (BWAT) is completed by the unit 	12/31/13

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F 314	<p>Continued From page 41</p> <p>conduct ongoing assessments to evaluate resident clinical condition, implement interventions as ordered, and monitor and evaluate the impact of interventions to provide timely necessary treatment and services to promote healing in a resident with a current identified pressure ulcer, and ensure that a resident with a history of pressure ulcer did not develop a new one, for 2 of 3 sample residents (#'s 60 & 93) reviewed for pressure ulcers. These failures placed Resident # 93 at risk for a delay in healing and decline in condition of a current pressure ulcer, and placed Resident # 60 at risk for recurrence of a recently healed pressure ulcer.</p> <p>Findings include:</p> <p>According to the facility's definitions contained in "Prevention and Treatment of Pressure Ulcers," dated 8/31/12, a Stage 1 pressure area has intact skin with non-blanchable redness; a Stage 2 has partial thickness skin loss presenting as a shallow open ulcer without slough (dead tissue); a Stage 3 has full thickness tissue loss; and a Stage 4 is full thickness tissue loss with exposed bone, tendon, or muscle.</p> <p>An Unstageable pressure ulcer is full thickness tissue loss in which the base of the ulcer is covered by slough or eschar (blackened dead tissue) in the wound bed. A Suspected Deep Tissue Injury is a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear.</p> <p>RESIDENT # 93</p>	F 314	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.</i></p> <p>manager. The care plan and care directive for resident #60 was updated to reflect the need to float her heels when in bed.</p> <ol style="list-style-type: none"> Residents who reside in the facility were reviewed for preventative skin care needs and care plans. Residents who have pressure ulcers were reviewed for appropriate wound care orders, daily monitors, and weekly assessments. The care plans were updated or revised as necessary. Nursing staff were inserviced on preventive skin protocols and pressure ulcer management. The DNS is responsible to monitor this system. The care and treatment of pressure ulcers is reviewed by the DNS weekly. The DNS will report on pressure ulcers each month in the PI meeting. 	12/31/13

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F 314	<p>Continued From page 42</p> <p>Resident # 93 was admitted to the facility from the hospital on [REDACTED]/13 with diagnoses to include [REDACTED], chronic [REDACTED] and an [REDACTED] stage [REDACTED] on the [REDACTED] with [REDACTED] ([REDACTED] tissue).</p> <p>The Minimum Data Set (MDS), an assessment tool, dated 9/26/13, indicated Resident # 93 was alert, oriented and able to make his/her needs known and required extensive assistance of two persons with transfers and bed mobility. No behaviors of rejection or resistance to care were identified.</p> <p>The physician's order, dated 9/28/13, instructed staff to cleanse Resident # 93's [REDACTED] heel with normal saline daily, apply a alginate (wound treatment), cover and wrap with gauze and change daily.</p> <p>Resident # 93's October Treatment Record (TR) documented daily dressing changes. There was no documentation of wound assessments on the TR.</p> <p>The "Daily Monitoring/Pressure Ulcers" form for October 2013 provided spaces for daily wound assessment, including wound status, dressing condition, surrounding skin, wound edges and associated pain. The form reflected documentation for only 7 days: October 1, 2, 3, 5, 6, 7, and 17.</p> <p>The physician's order, dated 10/31/13, instructed facility staff to administer Negative Pressure Wound Therapy (NPWT) to the pressure ulcer on Resident #93's [REDACTED] heel and to change the dressing 3 times per week and as needed.</p>	F 314		12/31/13
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F 314 Continued From page 43

According to the facility's policy, dated 4/28/13, NPWT removes infectious material from the wound with sub-atmospheric pressure (suction) to promote healing in wounds which have failed to proceed through normal stages of healing with standard treatment. (NPWT is also referred to as a "wound vac.")

Resident # 93's November TR instructed staff to cleanse the ● heel wound and change the wound vac dressing 3 times per week, and as needed. Specific days of the week for the dressing changes were not identified.

On Thursday, 11/7/13 at 9:15 a.m., review of interventions listed on Resident # 93's care plan for the ● heel pressure ulcer did not include the wound vac.

At 9:20 a.m., when advised that the surveyor would need to observe the dressing change to Resident #93's ● heel, Staff L said the dressing was done the previous day at the wound clinic and wasn't due again until Friday.

Staff L said wound assessments were documented on the TR. The surveyor and Staff L reviewed the November TR and noted there was only one assessment of the ● heel wound, on 11/5/13: ● heel wound measurements ● cm (centimeters) x ● cm x ● cm." There was no documentation on the TR indicating daily monitoring of the dressing.

At 10:24 p.m., Staff E said pressure ulcers were documented on the "Weekly Pressure Ulcer BWAT Report" (BWAT). The surveyor was able to locate only two BWATs, dated 9/19/13 and 10/3/13, for Resident # 93's ● heel ulcer. Staff E

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was unable to locate additional BWATs for the wound, daily monitoring of the dressing or any documentation of weekly wound assessments and treatments administered at the wound clinic.

At 1:14 p.m. at the surveyor's request by phone, the wound clinic sent by facsimile documents reflecting weekly assessments and treatments of Resident # 93's heel wound. The records indicted the size of the wound was diminishing. On 9/25/13 the wound measured x cm (centimeters). On 11/6/13 it measured by cm and the wound bed was debrided due to a hematoma.

On Tuesday, 11/12/13 at 8:15 a.m., Resident # 93 said the surveyor could watch the dressing change to the heel. The resident further stated s/he was "very concerned" that the dressing had not been changed since the last weekly visit to the wound clinic on Wednesday, 11/6/13. The resident stated, "It's supposed to be changed 3 times a week."

At 8:30 a.m., when advised that the surveyor would need to observe the dressing change to Resident #93's heel, Staff L stated, "It's not due today. It's due on Monday, Wednesday and Friday."

The surveyor and Staff L reviewed the TR and noted the TR did not specify which days the wound change was scheduled and that the dressing had not been changed since six days ago, on 11/6/13 at the wound clinic. Staff L said s/he did not know why the dressing had not been changed on Friday or Monday but s/he was extremely busy and would not have time to change the dressing during his/her shift. Staff L

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did not indicate a plan to assure the dressing change was completed that day.

At 10:14 a.m., Staff C stated the facility policy was to document pressure ulcer assessments weekly on the BWAT, noting appearance and size of the wound. Staff C said dressings were to be monitored daily and documented on the TR for appearance, drainage and intactness. Staff C said dressing changes should be scheduled on specific days, noted on the care plan and documented on the TR.

Staff C stated s/he would make sure Resident # 93's dressing change was done that day and the facility would educate licensed staff regarding treating, monitoring and documenting pressure ulcers.

At 11:30 a.m., Staff X notified the surveyor that Staff K, a nurse from a different unit, would perform the dressing change to Resident # 93's heel at the end of his/her shift. Staff X added that Staff K was a good choice because s/he was trained as a wound specialist.

At 2:38 p.m., during observation of the dressing change to Resident # 93's heel, the suction on the wound vac was intact and the wound bed was noted to be pink with slight bleeding, measuring by cm and cm deep. Staff K stated s/he had not previously observed the resident's wound but said, "based on extensive experience as a wound care nurse," it appeared to be healing well.

During the dressing change Resident # 93 stated the wound was somewhat painful during dressing changes, but otherwise there was little pain due

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F 314 Continued From page 46
to [REDACTED]. The resident again expressed concern that the dressing had not been changed in 6 days when it was ordered to be done 3 times per week.
Refer to F281.
RESIDENT # 60
Resident # 60 was admitted to the facility on [REDACTED]/13 with diagnoses including [REDACTED], [REDACTED], [REDACTED], [REDACTED] disease, and chronic [REDACTED] disease.
Physician Orders documented on 11/06/13 indicated to float heels at all times when in bed.
On 11/12/13 at 12:52 p.m., Resident # 60 observed lying in bed with heels resting directly on mattress and not floating. Staff J confirmed this.
On 11/12/13 at 1:00 p.m., Staff EE stated that she did not float Resident # 60's heels earlier today while resident was in bed.
On 11/12/13 at 12:55 p.m., the facility "Interim Plan of Care", a facility care plan that NAC's utilize to guide and direct resident care, did not reflect physician's order to float heels at all times when in bed. Staff EE confirmed this.

F 314

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F 318 SS=D 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION

F 318

F318

Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase

1. Resident #11 was reassessed for pain and mobility and is now receiving restorative nursing services. The care plan was revised and updated to reflect her current care needs and restorative services.

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F 318	<p>Continued From page 47</p> <p>range of motion and/or to prevent further decrease in range of motion.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to ensure 1 of 1 residents (# 11) identified with decline in range of motion received appropriate treatment and services to prevent further decline in range of motion. The facility demonstrated a system failure in communication between therapy departments and nursing that placed all residents at risk with potential worsening of range of motion and further decline in mobility, function, and quality of life.</p> <p>Findings Include:</p> <p>Resident # 11 initially admitted on [REDACTED]/13 and was re-admitted after hospitalization on [REDACTED]/13 with diagnosis of [REDACTED], [REDACTED] insufficiency, general [REDACTED], [REDACTED] pain), [REDACTED] (inflammation of [REDACTED]), and history of other [REDACTED] disorders.</p> <p>A quarterly minimum data set (MDS) dated 10/10/13 identified Resident #11 as cognitively intact. For activities of daily living (ADL) Resident #11 was identified as needing extensive assistance for dressing, toilet use, and bed mobility. The resident needed two staff person physical assistance for bed mobility and one staff for dressing and toileting.</p> <p>Upon re-admission to facility on [REDACTED]/13 Resident #11 was referred to Physical Therapy for</p>	F 318	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.</i></p> <ol style="list-style-type: none"> 2. Residents residing in the facility were assessed for mobility and restorative needs. Those who would benefit from a restorative nursing program are receiving restorative nursing services per the care plan. 3. A restorative team was developed and trained to provide appropriate restorative services daily to residents deemed appropriate by the interdisciplinary team. The interdisciplinary team was inserviced on the referral process for restorative nursing. A registered nurse was appointed to oversee the restorative nursing program. 4. The Director of Nursing is responsible to monitor restorative nursing services and the restorative nursing referral process. The DNS or her designee will perform an audit of restorative services monthly x 3 months and quarterly thereafter. The DNS will report on the restorative nursing system monthly x 3 months and as needed thereafter. 	12/31/13

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F 318	<p>Continued From page 48</p> <p>evaluation due to deconditioning. "Physical therapy (PT) Evaluation" dated 7/17/13 documented for Resident #11 to receive skilled PT for therapy evaluation, therapeutic activities, and gait training.</p> <p>"Physical therapy evaluation" dated 7/17/13 documented "additional medical diagnosis impacting PT included [redacted] and [redacted] pain and [redacted]." The patient/family goal documented was "to be more mobile."</p> <p>"Physical Therapy Progress Report" from 7/25/13 to 7/31/13 documented that Resident # 11 "made slow and steady progress this past week in spite of refusing to get out of bed or go to rehab gym twice." Knee pain was documented as a barrier to improvement. Potential for achieving goals was documented as good and that diathermy would be included for knee pain.</p> <p>A "Physical Therapy Discharge Summary" dated 8/6/13 documented PT was discontinued on 8/2/13. The comparative statement documented that Resident #11 "hasn't made significant progress since last progress note, as resident refuses to get out of bed." A Discharge Summary for PT documented Resident #11 was having pain in knees at a 9 out of 10 on a 0 to 10 pain scale and that electronic stimulation helped to decrease pain. It was documented that resident goals were not met due to resident refusing to get out of bed.</p> <p>Resident # 11 was not referred for restorative nursing services to provide mobility exercises or range of motion.</p> <p>On [redacted]/13 at 9:56 a.m. Staff I reported that Resident # 11 was discharged from PT due to</p>	F 318		12/31/13

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB CENTER- LAKEWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 11411 BRIDGEPORT WAY TACOMA, WA 98499
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F 318	<p>Continued From page 49</p> <p>refusing and not wanting to get out of bed. Staff I reported that after refusing a few times the resident is discharged from PT.</p> <p>On 11/7/13 at 10:17 a.m. Staff S reported that Resident # 11 was not getting restorative nursing services.</p> <p>On 11/7/13 at 10:23 a.m. Resident # 11 reported being on PT but not wanting it any longer and could not recall if he/she was put on a restorative program. Resident # 11 reported having a lot of pain, mostly in knees but also in hips. At 10:35 a.m. Resident # 11 reported being interested in having range of motion or restorative services as long as it was in his/her room or bed.</p> <p>On 11/7/13 at 11:15 a.m. Staff B confirmed that Resident # 11 was not referred to restorative services by PT. Staff B reported that when a resident refuses PT usually therapy gives a referral for restorative to try another option to prevent decline with the resident.</p> <p>On 11/7/13 at 11:50 a.m. Staff H reported that when a resident refuses PT, they are referred to restorative services to focus on ADLs and mobility. Staff H confirmed that Resident # 11 would benefit from a restorative program and that the resident is at risk for abduction, hip flexion, knee flexion and ankle flexion. Staff H confirmed that there was no documentation to show that Resident #11 was referred to restorative services or that there was documentation of the resident refusing the services.</p> <p>Review of Resident # 11's care plan dated 2/15/13 for the focus of ADL self-care performance deficit related to pain revealed no</p>	F 318		12/31/13

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F 318	<p>Continued From page 50</p> <p>goal or interventions to improve ADLs with pain management. The interventions did not address what needed to be done to relieve pain and to improve ADL performance.</p> <p>Review of Resident # 11's initial admission care plan dated [REDACTED]/13 for the focus of chronic [REDACTED] and [REDACTED] pain related to [REDACTED] with a goal to meet and set goals by therapy to maintain/improve ADL performance. The care plan for Resident # 11's pain had not been updated since the original admission date and the interventions in place were not reassessed or revised to ensure that the resident is getting adequate pain management.</p> <p>On 11/8/13 at 9:22 a.m. Resident # 11 reported having pain in [REDACTED] and [REDACTED] for a long time. Resident # 11 reported that being repositioned, sitting up on the side of bed, and that hot showers helped with the pain. Resident # 11 confirmed that the facility did not offer alternative interventions to relieve pain.</p> <p>Resident # 11 reported that he/she was interested and willing to exercises with restorative in bed. Resident # 11 reported the reason for refusing PT was due to pain and not being able to get the assistance needed to get back in bed after PT. Resident # 11 reported being tired after PT and that it was frustrating to have to wait to get in bed, so he/she did not want PT any longer.</p> <p>On 11/8/13 at 12:01 p.m. Staff C reported that the resident's care plans should be updated when returning from the hospital, with any changes and with each MDS.</p> <p>On 11/8/13 at 3:30 p.m. Staff C reported that</p>	F 318		12/31/13
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F 318	<p>Continued From page 51</p> <p>he/she spoke with Resident # 11 and the resident reported that pain was the reason he/she did not want to get out of bed. Resident # 11 also reported to Staff C that he/she wanted to try a restorative program.</p> <p>Failure to re-assess, monitor and follow up with Resident #11's pain management resulted in the resident refusing therapy due to the pain. This failure placed the resident at risk for decline in mobility, strength and quality of life.</p> <p>Failure to re-assess and revise Resident # 11's care plan since admission on [REDACTED]/13 placed the resident at risk for decreased quality of care. Without updating the care plan staff is unable to identify how to care for Resident # 11's care needs related to pain, and how it impacted the refusal of therapy and ADLs.</p>	F 318	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.</i></p>	
F 325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 325	<p>F325</p> <ol style="list-style-type: none"> 1. Resident #15 was reassessed for nutritional needs and ability to eat. He was placed in the assisted dining room for meals where his intake has improved. His weight has stabilized. The care plan was updated to reflect this change. 2. Residents with weight fluctuations or weight loss were reviewed by the Registered Dietician and interdisciplinary team. The physician was notified of each resident known to be experiencing weight loss. Appropriate interventions are in place and care plans were updated as necessary. 	12/31/13

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F 325

Continued From page 52

Based on observation, interview and record review, the facility failed to ensure 1 of 3 Sampled Residents (# 15) reviewed for nutrition was comprehensively assessed and received adequate interventions regarding weight loss. Failure to ensure interventions were in place to monitor and/or maintain this resident's nutritional well-being created the potential for poor nutritional management and unplanned weight loss.

Findings included:

Resident #15 was admitted on [redacted]/13 with multiple medical diagnoses including [redacted] failure, [redacted] status, [redacted] and [redacted]. The Care Plan [CP], created 9/6/13, indicated the resident was to consume adequate calories to maintain his energy and weight between [redacted] pounds. The CP also indicated: "Notify RD [registered dietitian], family and physician of significant weight changes."

Resident # 15 was observed in the main dining room eating meals independently on 11/4 and 11/8/13 at 12:30 p.m.

According to the record, the following weights for this resident were: On 9/3/13, "[redacted] pounds per wheelchair." One week later on 9/10/13, the resident's weight indicated a [redacted] pound loss at "[redacted] pounds in wheelchair." Two days later on 9/13/13, the resident's weight was up [redacted] pounds to "[redacted] pounds Manual." On 9/26/13, the resident's weight was "[redacted] pounds Manual." On 10/8/13 the resident's weight was [redacted] pounds Manual." The last documented weight on 10/25/13 was

F 325

This Plan of Correction is the center's credible allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.

- Nursing staff (licensed nurses and certified nursing assistants) were inserviced on obtaining weights and reweights, documentation of weights, and interventions to prevent weight loss. A referral process was implemented for nursing staff to communicate nutritional needs to the Registered Dietician. The scales were evaluated and certified by an outside vendor for accuracy. The interdisciplinary team meets weekly to review weights and weight changes. Care plans are updated and revised as necessary in the IDT meeting. The physician is informed of weight loss timely.
- The Director of Nursing is responsible to monitor resident weights and the nutritional status of each resident. The RD reports problems with weights to the DNS as they occur. The DNS or her designee will complete an audit of the nutritional program and weights monthly x 3 months and quarterly thereafter. A report will be made to the PI committee on this system and weight loss monthly and as needed.

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F 325 Continued From page 53
" pounds manual."

Review of the 9/30/13 updated CP revealed no changes from the 9/6/13 CP and failed to indicate staff awareness and/or interventions identified for the significant weight fluctuations.

On 11//8/13 at 2:15 p.m., during interview with the facility consultant, s/he stated she could not find further weight management documents to indicate staff recognized and/or implemented appropriate interventions to ensure accuracy of weights obtained and to manage the significant weight loss and gains experienced by the resident since admission.

F 325

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F 329 SS=D 483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including 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 record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically

F 329

- F329
1. The physician for resident #162 assessed the resident and reviewed the prescribed medication orders. Changes were made to the medication regime. The resident is now receiving the required monitoring for effects and side effects of her medications.
 2. The medication administration records for residents residing in the facility were reviewed for missing required monitoring of prescribed medication.
 3. Licensed nurses were inserviced on the requirement for monitoring of certain prescribed medications and

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F 329	<p>Continued From page 54</p> <p>contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review it was determined that the facility failed to ensure adequate justification for the use of medication, consistently monitoring and assessments for behaviors and hours of sleep for 1 of 5 current sampled residents (#162) reviewed for unnecessary drugs in the Stage 2 sample. This failure placed the resident at risk for receiving substandard quality of care and diminished quality of life.</p> <p>Findings Include:</p> <p>Resident # 162 was admitted to facility on [REDACTED]/13 after hospitalization with diagnosis of [REDACTED] disease, [REDACTED], and [REDACTED].</p> <p>Review of medication record" initiated on 11/10/13 revealed the medication [REDACTED] milligrams (mg) by mouth every night as needed for insomnia and [REDACTED] mg every night by mouth for depression.</p> <p>On 11/12/13 at 1:40 p.m. Resident # 162 reported that the [REDACTED] is not working and he/she is not sleeping well. Resident # 162 reported being tired, hurting and that spirits were low.</p>	F 329	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.</i></p> <p>their potential side effects. These included hypnotics, antidepressants, antipsychotics, and anxiolytics. The interdisciplinary team reviews each resident's antipsychotic medication quarterly and with any change for appropriate monitoring and potential for decrease.</p> <p>4. The Director of Nursing is responsible to monitor this process. An audit of antipsychotic drug monitoring will be conducted monthly by the DNS for 3 months and as needed thereafter. A report will be made to the PI committee on this process x 3 months and thereafter a report will be made by the Social services department monthly regarding antipsychotic drug use and compliance with facility protocol for such use.</p>	12/31/13
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F 329	<p>Continued From page 55</p> <p>Resident # 162 was not monitored for hours of sleep to ensure that the [REDACTED] was an effective sleep aide or if there were any side effects from the medication.</p> <p>Resident # 162 was not monitored while receiving [REDACTED] for depression. Resident # 162 was not monitored for effectiveness, side effects, or postural blood pressures.</p> <p>On 11/12/13 at 12:23 p.m. Staff K reported that Resident # 162 was usually really tired after [REDACTED], not very talkative, and seemed depressed.</p> <p>On 11/12/13 at 1:35 p.m. Resident # 162 was observed resting in bed lying on left side with oxygen in place and family at the bedside.</p> <p>On [REDACTED]/13 at 1:09 p.m. Staff D reported that Resident # 162 was recently admitted. Staff D confirmed that the hours of sleep, postural blood pressures, behaviors, and side effects of medications were not being monitored. At 1:23 p.m. Staff D reported after reviewing the policy, monitoring of antidepressants and sleep aides should have been documented since admission.</p> <p>Minimum Data Set (MDS) an assessment tool had not been completed, as well as care plan for this admission.</p>	F 329	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.</i></p>	
F 333 SS=D	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p>	F 333	<p>F333</p> <ol style="list-style-type: none"> The physician for resident #163 was notified of the two consecutive missing doses of antibiotic. The resident was assessed for adverse effects of the missing doses. 	12/31/13

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F 411	<p>Continued From page 60</p> <p>appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, it was determined the facility failed to provide necessary dental services for identified dental problems for 1 Medicare resident of 3 sample residents (#75) reviewed for dental services. This failure placed the resident at risk for continued dental problems including broken teeth, missing teeth and difficulty with chewing.</p> <p>Findings include:</p> <p>Resident #75 was admitted to the facility from the hospital on [REDACTED]/13 with multiple medically disabling conditions.</p> <p>Resident #75's admission Minimum Data Set (MDS), an assessment tool, dated 10/15/13, indicated the resident was alert, oriented, and able to make him/herself understood.</p> <p>The MDS indicated the resident had no missing teeth or other dental problems even though the admission assessment indicated the resident had missing teeth.</p> <p>Dental problems were not identified on Resident #75's care plan.</p> <p>Resident #75's admission assessment, dated [REDACTED]/13, indicated the resident had missing teeth.</p>	F 411	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.</i></p> <ol style="list-style-type: none"> Residents residing in the facility were assessed for oral/dental health and referrals for further dental care were made as necessary. Care plans were updated to accurately reflect current oral/dental conditions. The care directives were updated to reflect care needs to promote oral/dental health and hygiene. The licensed nursing staff were educated on oral/dental assessment and documentation. The certified nursing assistants were inserviced on oral and dental hygiene. A referral system was implemented to communicate oral/dental health needs to the social services department for appointment and transportation scheduling. The social services department has developed a tracking system to ensure that follow up of dental conditions continue until the problem is resolved or treatment ends. The Director of Nurses is responsible for monitoring this system. The DNS or her designee will audit oral hygiene and the referral process monthly x 3 months 	12/31/13

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F 411	<p>Continued From page 61</p> <p>Resident #75's physician orders included an order for a regular diet with regular texture.</p> <p>On 11/06/13 at 10:13 a.m., Resident #75 was observed to have several broken teeth in the upper front and one missing tooth in the lower front of his/her mouth. The resident said s/he sometimes had tooth pain and stated, "I need to have these broken teeth taken out and get dentures or a new partial. The old partial I had didn't fit right and it ground down and broke my teeth."</p> <p>Resident #75 said no one at the facility had asked the resident about his/her teeth or if the resident had tooth or mouth pain. The resident said s/he lost 5 teeth 1½ years ago and had not been able to see a dentist due to difficulty walking and lifting legs into a car to get to an appointment.</p> <p>Resident #75 said s/he had difficulty chewing food. The resident said, "I put 'No sandwiches' on my food list because I can't bite through them. It's hard to chew. I have to cut food small so I can get it to the back of my mouth. It's hard to cut food with just a butter knife."</p> <p>On 11/7/13 at 12:07 p.m., Staff B said, "We have a dentist that comes to the facility every 2 months and he was just here yesterday."</p> <p>On 11/7/13 at 2:57 p.m., Staff F said s/he was responsible to compile a list of residents for the dentist to visit and identified residents who needed to see the dentist by consulting with the Resident Care Managers and nursing assistants, and reviewing the internal communication log on each unit. No staff indicated Resident #75 had</p>	F 411	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.</i></p> <p>and as needed thereafter. A report will be made to the PI committee. Problems with this process will be brought to the PI committee for review and resolution.</p>	12/31/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505347	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/15/2013
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB CENTER- LAKEWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 11411 BRIDGEPORT WAY TACOMA, WA 98499
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F 333	<p>Continued From page 56</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, it was determined the facility failed to ensure residents were free of significant medication errors when 2 consecutive doses of [REDACTED] antibiotic were not administered to 1 of 8 sample residents (# 163) reviewed for medication administration. This failure placed the resident at risk for diminished effectiveness of the antibiotic and delayed recovery from a life-threatening [REDACTED] infection.</p> <p>Findings include:</p> <p>Resident # 163 was admitted to the facility on [REDACTED]/13 for administration of [REDACTED] after being hospitalized and admitted to the intensive care unit with acute [REDACTED] and acute [REDACTED].</p> <p>Physician orders for Resident # 163 included [REDACTED] (antibiotic) [REDACTED] milligrams every 6 hours with a stop date of 11/24/13.</p> <p>On 11/12/13 at 5:30 a.m., observation revealed that Resident # 163's doses of [REDACTED] were mixed in [REDACTED] milliliter bags of normal saline (NS) which were attached to the vials of [REDACTED] to be mixed at the time of administration. Plastic bags containing individual doses of the medication and NS were stored in the medication room in a box labeled with Resident #163's name.</p> <p>On 11/13/13 at 8:10 a.m., Resident # 163 stated</p>	F 333	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.</i></p> <ol style="list-style-type: none"> The medication administration records for residents residing in the facility were reviewed for missing doses. No other missing doses were identified. Licensed nurses were educated on the proper procedure for reordering of medications and what to do if doses of an ordered medication are missing or not available from the pharmacy. Medication administration records are audited regularly for missing doses. The DNS is responsible for ensuring that residents have their prescribed medications available from the pharmacy and the physician notified if medication will not arrive timely. The nursing staff will notify the DNS if doses of prescribed medication are not available from pharmacy and the physician will be notified. Problems with medication delivery will be brought to the PI committee for review and resolution. 	12/31/13
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 333	<p>Continued From page 57</p> <p>that on 11/9/13 at 11:00 p.m., when a dose of the antibiotic was due, Staff U informed the resident there were no doses available. The resident stated s/he missed 2 consecutive doses of the medication and was very concerned about the potential negative effect on his/her recovery from the infection.</p> <p>Review of Resident # 163's Medication Record (MR) revealed the antibiotic was scheduled at 5:00 a.m., 11:00 a.m., 5:00 p.m., and 11:00 p.m. The doses on 11/8/13 at 11:00 p.m. and 11/9/13 at 5:00 a.m. were marked "NA." The Nurse's Medication Notes, signed by Staff U, indicated the doses were missed because the medication was "not available." Staff U documented s/he called the pharmacy and the medication would arrive on the morning of 11/9/13.</p> <p>At 9:03 a.m., Staff U stated that on 11/8/13 at 10:45 p.m., s/he discovered the box in the medication room for storing Resident # 163's [REDACTED] was empty. Staff U searched the medication room but no doses of the antibiotic were found.</p> <p>Staff U called the pharmacy and was told a refill of the medication had not been ordered. Staff U verbally requested the medication be sent as soon as possible and sent a refill order by facsimile at 11:11 p.m.</p> <p>Staff U stated s/he did not notify the physician of the 2 missed doses of [REDACTED] and did not know if any other staff reported it. No documentation was found to indicate the physician was notified.</p> <p>The MR indicated the next dose of [REDACTED]</p>	F 333		12/31/13

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F 333	<p>Continued From page 58</p> <p>was administered on 11/9/13 at 11:00 a.m., 12 hours late and 18 hours after the previous dose on 11/8/13 at 5:00 p.m.</p> <p>On 11/13/13 at 11:51 a.m., Staff C stated the facility procedure for generating pharmacy refill orders for IV antibiotics was that medication nurses were to send pharmacy refill orders by facsimile when only 3 or 4 doses were left in the resident's supply. Staff C confirmed there was no refill order for Resident # 163's [REDACTED] before the order sent by Staff U on 11/8/13.</p> <p>The failure to ensure the antibiotic was available as ordered placed the Resident #163 at risk for diminished effectiveness of the antibiotic and delayed recovery from a life-threatening [REDACTED] infection.</p> <p>Refer to F281</p>	F 333	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.</i></p>	
F 371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 371	<p>F 371</p> <ol style="list-style-type: none"> 1. A new drying rack was purchased and is in use. Dishes and equipment are allowed to dry completely before being stacked and stored to prevent moisture from remaining. 2. Residents residing in the facility are at risk for contaminated dishes when moisture accumulates. 3. Dietary staff were inservice regarding the facility protocol for dish drying before storage. 	12/31/13

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F 371	<p>Continued From page 59</p> <p>Based on observation, interview and record review, the facility failed to ensure that food was distributed and served under sanitary conditions. This failure placed all residents at risk of consuming potentially contaminated food.</p> <p>Findings include:</p> <p>11/07/13 at 12:12 p.m., approximately 5 to 10 milliliters of water was observed on a burgundy plate covers stored and stacked on top of metal cart. Cookie sheets and metal mixing bowls stacked upside down on metal shelves were covered in water droplets. Moisture was found in food processor/chopper. Staff Z confirmed water droplet and moisture present on all four items.</p> <p>On 11/20/13 at 1:30 p.m., facility policy titled "Dishwashing: Dish Machine" stated the following: "# 19. Place racks on the clean dish table/area and allow the dishes and flatware to air dry...# 22. Stack like items together ...in the appropriate storage location."</p>	F 371	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.</i></p> <p>4. The Executive Director is responsible for monitoring this process. The Dietary Manager and Registered Dietician perform monthly inspections of the kitchen and processes. The Executive Director performs regular audits of the kitchen at least monthly and reviews audits completed with the DM and RD. A report will be made to the PI committee by the DM monthly and as needed thereafter for review of problems and resolution.</p>	
F 411 SS=D	<p>483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS</p> <p>The facility must assist residents in obtaining routine and 24-hour emergency dental care.</p> <p>A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making</p>	F 411	<p>F 411</p> <p>1. Resident #75 was assessed for oral/dental health and dental problems. An appointment for dental services has been made. The MDS was corrected to reflect the resident's current dental condition. The care plan was revised and updated to accurately reflect the resident's oral/dental status and care needs.</p>	12/31/13

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F 411 Continued From page 62
missing teeth or needed dental services.

On 11/12/13 at 10:15 a.m., Staff X said an oral assessment should be conducted by a nurse for each resident on admission and quarterly.

On 11/12/13 at 12:28 p.m., Staff V said that the nurse who conducted the MDS assessment was expected to perform a full physical assessment, including oral. Staff V did not conduct the MDS assessment for Resident #75 but said s/he had seen the resident's mouth and "I knew s/he had bad teeth." Staff V said Resident #75 should have been referred to Social Services for dental services.

On 11/13/13 at 8:00 a.m., Resident #75 said if offered an opportunity and assistance to see a dentist and have dentures or a new partial made, s/he would eagerly agree to do so.

The facility failed to provide necessary dental services for Resident #75 when the resident was noted to have missing teeth and was not referred for dental services, placing the resident at risk for ongoing problems including tooth pain and difficulty eating.

F 411

This Plan of Correction is the center's credible allegation of compliance.

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F 412 SS=D 483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS

The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for

F 412

F 412

1. Resident # 137 was assessed for oral/dental health. The MDS was corrected to reflect the resident's current dental condition. The care plan was revised and updated to accurately reflect the resident's oral/dental status and care needs. The resident will be visited by the denturist on the next visit.

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F 412	<p>Continued From page 63</p> <p>transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, it was determined the facility failed to provide necessary dental services for identified dental problems for 1 Medicaid resident of 3 sample residents (#137) reviewed for dental services. This failure placed the resident at risk for continued dental problems including painful, ill-fitting dentures and difficulty with eating.</p> <p>Findings include:</p> <p>Resident #137 was originally admitted to the facility on [redacted]/13 and was readmitted on [redacted]/13 with diagnoses to include [redacted] with [redacted] sided [redacted] and [redacted] disease.</p> <p>Resident #137's Minimum Data Set (MDS), an assessment tool, dated 8/17/13, indicated the resident was alert, oriented, and able to make him/herself understood. The resident was non-ambulatory and required limited assistance with eating.</p> <p>The MDS indicated the resident had no missing teeth or other dental issues even though the resident had been identified as being edentulous.</p> <p>Dental problems were not identified on Resident #137's care plan.</p> <p>The speech pathology evaluation, dated 7/28/13,</p>	F 412	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.</i></p> <ol style="list-style-type: none"> 2. Residents residing in the facility were assessed for oral/dental health and referrals for further dental care were made as necessary. Care plans were updated to accurately reflect current oral/dental conditions. The care directives were updated to reflect care needs to promote oral/dental health and hygiene. 3. The licensed nursing staff were educated on oral/dental assessment and documentation. The certified nursing assistants were inserviced on oral and dental hygiene. A referral system was implemented to communicate oral/dental health needs to the social services department for appointment and transportation scheduling. The social services department has developed a tracking system to ensure that follow up of dental conditions continue until the problem is resolved or treatment ends. 4. The Director of Nurses is responsible for monitoring this system. The DNS or her designee will audit oral hygiene and the referral process monthly x 3 months 	12/31/13
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F 412

Continued From page 64 indicated Resident # 137 had severe [REDACTED] difficulty), was [REDACTED] (had no natural teeth) and had dentures but did not wear them. No reason was given as to why the resident did not wear the dentures. A mechanical soft diet was ordered and the resident's stated goal was to "eat again."

The speech pathology evaluation, dated 8/12/13, indicated Resident #137 had mild to moderate [REDACTED]. A pureed diet was ordered and the resident's stated goal was "to eat regular food."

Physician orders, dated 10/10/13, indicated Resident #137's diet was upgraded to regular solids with all meat chopped.

On 11/4/13 at 4:02 p.m., Resident #137 was observed to be edentulous and not wearing dentures. The resident said he/she had dentures made "before my [REDACTED]." The resident said s/he did not keep the dentures at the facility, did not wear the dentures and said, "They don't fit right. They're uncomfortable and make my mouth hurt."

On 11/7/13 at 11:20 a.m., Staff KK said Resident #137 was advanced from a pureed diet to mechanical soft. At the resident's request, the resident was recently reevaluated by Staff KK and determined to be appropriate for a regular diet. Staff KK said the resident's [REDACTED] had mostly resolved and stated, "When I assessed [the resident] for mechanical soft, it was in part because [s/he] was edentulous." During the most recent evaluation Staff KK said the resident demonstrated s/he was able to "break down" whole pieces of meat "by gumming it" and was advanced to a regular diet.

F 412

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and as needed thereafter. A report will be made to the PI committee. Problems with this process will be brought to the PI committee for review and resolution.

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F 412	<p>Continued From page 65</p> <p>Staff KK said when s/he observed a resident to be edentulous s/he usually referred the resident to social services or nursing for dental services, but Staff KK could not recall why this did not occur with Resident #137. Staff KK could not recall if the resident indicated the reason for not wearing his/her dentures.</p> <p>On 11/7/13 at 12:07 p.m., Staff B said, "We have a dentist that comes to the facility every 2 months and he was just here yesterday."</p> <p>On 11/7/13 at 2:57 p.m., Staff F said s/he was responsible to compile a list of residents for the dentist to visit and identified residents who needed to see the dentist by consulting with the Resident Care Managers and nursing assistants, and reviewing the internal communication log on each unit. No staff indicated Resident #137 was edentulous or needed dental services.</p> <p>On 11/12/13 at 10:15 a.m., Staff X said an oral assessment should be conducted by a nurse for each resident on admission and quarterly.</p> <p>On 11/12/13 at 12:28 p.m., Staff V said that the nurse who conducted the MDS assessment was expected to perform a full physical assessment, including oral. Staff V did not conduct the MDS assessment for Resident #137 but said, "When a resident has dentures and doesn't wear them, staff should find out why. If the resident says the dentures are uncomfortable or do not fit the resident should be placed on the list to be seen by the dentist."</p> <p>On 11/12/13 at 2:10 p.m., Resident #137 said s/he would like new dentures because it would look better and would make it easier to eat, but the</p>	F 412		12/31/13
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F 412	Continued From page 66 resident did not think s/he could afford them. The resident said if offered an opportunity to visit a dentist and get a new set of dentures s/he would do it.	F 412	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
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. (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.	F 441	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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. F441 1. Education has occurred on catheter care with return demonstration for certified nursing assistants. Education is planned for hand hygiene, perineal care, handling of linens, and general infection control practices. 2. The SDC has been educated regarding infection surveillance and analysis of infection rates to include training needs of staff related to infection trends and how to record the education. 3. The monthly infection rate, surveillance, and analysis will be presented in the monthly PI meeting. If not previously addressed, the PI committee will make recommendations for further training needs and provide follow up. 4. The Executive Director and Director of Nursing are responsible to ensure follow up of PI committee recommendations.	12/31/13

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F 441	<p>Continued From page 67</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:</p> <p>Based on observation, interview and record review, the facility failed to implement an effective infection control program with monitoring to demonstrate ongoing analysis of trended infectious organisms. Additionally, the facility failed to follow its urinary catheter care infection control procedure to prevent possible urinary tract infections (UTI's) when staff did not complete proper catheter care for one of one resident (# 8) reviewed for catheter care. This failure places residents at risk of developing and contracting potential infections.</p> <p>Findings include:</p> <p><CATHETER CARE></p> <p>Facility procedure titled "Indwelling Urinary Catheter Care" reads as follows: "#9. Wash perineum beginning at the junction of the catheter tubing and meatus working outward to the surrounding perineal structures with soap and warm water ...cleaning from front to back ...change gloves ...# 10. Cleanse area well and remove all debris from catheter insertion site ...do no pull catheter."</p> <p>On 11/06/13 at 9:40 a.m., Staff O performed</p>	F 441		12/31/13
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505347	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/15/2013
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB CENTER- LAKEWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 11411 BRIDGEPORT WAY TACOMA, WA 98499
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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 441	<p>Continued From page 68</p> <p>catheter care for Resident # 8. Staff O was observed swiping with moistened washcloth down middle of the genitalia, wiping front to back, then coming back up with the same washcloth to the meatus/catheter insertion site and wiping catheter from meatus down catheter not holding catheter to prevent pulling.</p> <p><INFECTION CONTROL PROGRAM></p> <p>During a review of the facility's infection control program with Staff G on 11/07/13 at 10:05 a.m., it was discovered that although Staff G was tracking and trending patterns of infections, there was no evidence that any analysis was performed of the identified patterns or trends of resident infections.</p> <p>On 11/07/13 at 10:05 3 a.m. in an interview, Staff G reported that the facility's number of UTI 's had increased from four in June to ten in July/ August, and then finally to seven in September.</p> <p>On 11/07/13 at 10:05 a.m., as a result of an increase in UTI's, Staff G decided to incorporate some employee training in September, which included hand hygiene, perineal care and catheter care.</p> <p>On 11/07/13 at 10:05 3 a.m. to address the increasing number UTI's in the facility, Staff G stated that she decided to provide employee training of hand hygiene, perineal care and catheter care for evening shift. However, when asked why s/he chose the evening shift she was unable to provide any analysis or identified patterns that would indicate that evening shift required additional catheter care training. In addition, Staff G confirmed that the majority of</p>	F 441		12/31/13
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB CENTER- LAKEWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 11411 BRIDGEPORT WAY TACOMA, WA 98499
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F 441	Continued From page 69 catheter care was performed by day shift during a.m. care. On 11/07/13 at 10:05 3 a.m. during an interview, Staff G was unable to neither provide any evidence of documentation of educational information presented nor list of employees present during most recent employee training which included hand hygiene, perineal care and catheter care incorporated to address the increasing number of UTI's in the facility.	F 441	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.</i>	
F 518 SS=F	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to properly train staff in regards to emergency preparedness and disaster training. This failure places the resident at risk for harm during an emergency situation. Findings include: On 11/13/13 at 9:56 a.m., Staff A stated that Staff AA was responsible for disaster and emergency preparedness training of facility staff.	F 518	F518 1. An emergency preparedness drill was held prior to the end of the survey with a simulated earthquake. 2. A review of the disaster manuals was completed and the manuals received the necessary updates per company protocol. 3. A calendar for disaster drills will be established. Staff will be educated on disaster preparedness and disaster manuals. Disaster preparedness will be discussed in the new employee orientation program. 4. The Executive Director is responsible for ensuring that disaster and emergency preparedness occurs. Disaster drills will be discussed in the monthly PI meeting as they are scheduled.	12/3/13

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB CENTER- LAKEWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 11411 BRIDGEPORT WAY TACOMA, WA 98499
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F 518	<p>Continued From page 70</p> <p>On 11/08/13 at 2:12 p.m., Staff AA was unable to produce any documentation that staff or newly hired employees are trained in Emergency/Disaster Preparedness.</p> <p>On 11/08/13 at 2:50 p.m., Staff DD stated that during new employee training, s/he does not recall receive any training in disaster and emergency preparedness.</p> <p>On 11/08/13 at 2:53 p.m., Staff CC was hired two and half months ago and doesn't remember disaster and emergency preparedness training. When asked what she would do if she saw an armed intruder, she stated she would ensure that residents are quickly put in their rooms and then would pull the fire alarm in order to alert all other staff members.</p> <p>On 11/08/13 at 2:00 p.m., review of facility policy titled "Emergency Preparedness" under "Armed Intruder" it read "Remain calm ...call 911 ...if assailant is asking for ...drugs ...give it to them. If person leaves ...watch which direction ...they go ...and note type of car and license plate ...if assailant is focused on harming you ...decide ... if you can use reasonable force ...etc ..." with no mention of the pulling fire alarm.</p> <p>On 11/08/13 at 2:58 p.m., Staff BB doesn't recall receiving training on what to do with carbon monoxide poisoning. Staff BB was hired a year and half ago and remembers receiving elopement and armed intruder training but no training for carbon monoxide poisoning. In addition, Staff BB does not recall any disaster and emergency preparedness training since her new employee</p>	F 518		12/31/13
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB CENTER- LAKEWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 11411 BRIDGEPORT WAY TACOMA, WA 98499
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F 518	Continued From page 71 orientation a year and a half ago.	F 518		12/31/13

12/31/13