

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

PRINTED: 05/31/2013
FORM APPROVED
OMB NO. 0938-0391

1290

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505404	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/22/2013
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NAME OF PROVIDER OR SUPPLIER BETHANY AT PACIFIC	STREET ADDRESS, CITY, STATE, ZIP CODE 916 PACIFIC AVENUE 3RD-5TH FLOORS EVERETT, WA 98201
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Bethany At Pacific on 05/14/13, 05/15/13, 05/16/13, 05/17/13, 05/20/13, 05/21/13 and 05/22/13. A sample of 36 residents was selected from a census of 107. The sample included 28 current residents, the records of eight former and/or discharged residents, and two supplemental residents.</p> <p>Survey team members included: , MSW , MS, RD , BSN, RN , BSN, RN , BSN, RN</p> <p>The survey team is from: Department of Social and Health Services Aging and Long Term Support Administration Residential Care Services District 2, Unit A 3906 172nd Street NE, Suite 100 Arlington, Washington 98223-4740</p> <p>Telephone: (360) 651-6850 Fax: (360) 651-6940</p> <p> Residential Care Services</p>	F 000	<p>F 000</p> <p>The Plan of Correction is submitted as required under Federal and State statutes and regulations. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby denied. The submission of this plan does not constitute agreement by the facility that the state surveyor's findings or conclusions are accurate, that the findings constitute deficiencies, or that the scope and severity determinations regarding the alleged deficiencies were correctly applied.</p> <p style="text-align: right;">JUN 17 2013 ADSA/RCS Region 3</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Debra J. James</i>	TITLE ADMINISTRATOR	(X6) DATE 6-14-13
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F 225	<p>F 225</p> <p>The facility will continue to ensure policies and procedures for the prevention of abuse and neglect are consistently implemented.</p> <p>Resident #68 – A thorough incident investigation was completed on 5/23/13 which included staff interviews and completion of the initial Incident Log entry. Abuse and neglect were ruled out.</p> <p>Resident #119 – Bruise has since been investigated thoroughly and was identified to be from an attempted IV insert by EMT's.</p> <p>A thorough investigation will be completed on all falls and bruises. All falls and bruises will be logged with findings within 5 days as required by the Department.</p> <p>All Licensed Nurses will be re-inserviced on policies and procedures for prevention of abuse and neglect which will include but not be limited to thorough incident investigations, recording and reporting.</p>		

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F 225	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure policies and procedures for the prevention of abuse and neglect were consistently implemented. Failure to conduct a thorough investigation for two (#s 68 and 119) residents who sustained injuries placed residents at risk for abuse and/or neglect.</p> <p>Findings include: RESIDENT #68 On 05/14/13 Resident #68 was observed in the 3rd floor main dining room. The resident had blue/green/yellow bruising that encompassed the left side of her face from the forehead to the lower jaw and circular bruising to both eye orbits. A laceration with visible stitches was also observed in the center of the resident's forehead.</p> <p>Review of the most recent quarterly Minimum Data Set assessment, dated 04/09/13, noted the resident required physical assistance from staff for most activities of daily living, (i.e. dressing, grooming, hygiene and transfers). It also assessed the resident used a wheelchair and needed assistance from staff when moving from one location to another.</p> <p>Review of the facility Incident Log revealed the resident experienced a fall on 05/04/13. Under "Type of Injury", it was noted "yes", with no further descriptive data. While it was noted the resident went to the Emergency Room, there was no indication on the Log whether the State Hotline was notified. In addition, there was no entry under the "Findings" heading to indicate what the</p>	F 225	<p>Continued from page 2</p> <p>An audit will be performed on all similar incidents of residents to ensure a thorough investigation has been conducted, recorded, and reported as required by the Department. Findings will be reviewed at monthly Continuous Quality Improvement Meeting.</p> <p>Nurse Managers to monitor.</p> <p>Director of Nursing to ensure compliance.</p> <p>6/30/13 and Ongoing.</p>	

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F 225	<p>Continued From page 3 investigation had determined.</p> <p>Review of the Incident Investigation Report (IIR), provided by the facility, revealed staff noted the fall occurred at 4:00 p.m. on 05/04/13. It indicated staff was alerted the resident was on the floor after her roommate turned on her call light. The IIR noted the resident was trying to reach her TV remote control on the "nightstand" and identified the resident had a self-inflicted injury.</p> <p>The only statement attached to the IIR was obtained from the Nursing Assistant (NA) who responded to the roommate's call light. The NA documented she was not assigned to care for the resident at the time of the fall and she responded "I don't know" to questions asked on the "Caregivers Statement for Incident Investigation Report." There was no information regarding what the resident was doing prior to the fall or when she was last assisted by the caregiver assigned to her.</p> <p>A summary statement, dated 05/15/13, indicated the resident was sent to the emergency room "shortly" after the fall occurred. However a progress note entry, dated 05/04/13, noted the resident left the facility at the of the beginning of the nocturnal shift, which staff reported was 10:00 p.m. The Nurse Manager, Staff I, was interviewed about the investigation on 05/22/13 at 9:40 a.m. She reported she was not present in the facility at the time the fall occurred and indicated she first observed the injury two days later. She stated the left side of the resident's face was bruised when she observed it. She stated the injury had not been reported to the state hotline because the resident told the staff</p>	F 225	See Page 2	

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F 225	<p>Continued From page 4 what happened.</p> <p>When asked why the NA assigned to provide care to the resident at the time of her fall, or the resident's roommate who was the first to realize the resident had fallen were not interviewed, Staff I stated she did not feel it was necessary. She was unable to explain how a thorough investigation was conducted given a lack of interviews from individuals who, in addition to the resident, could best provide data regarding the incident.</p> <p>Following the survey exit date, the facility provided an interview obtained from the caregiver assigned to the resident at the time of her fall. The facility was unable to explain why the interview had not been attached to the IIR nor provided at the time requested, nor could they explain why Staff I had stated the caregiver was not interviewed during the investigation. Failure to ensure all investigative data was available placed staff at risk to be unable to accurately determine the cause of an incident.</p> <p>The IIR did not accurately identify the injuries the resident sustained nor did it include relevant interview data, such as an interview with the staff assigned to provide care and / or the roommate who turned on her call light to get assistance. Failure to ensure the incident was thoroughly investigated left the facility without sufficient information to rule out abuse and or neglect. Additionally, the facility failed to completely log the incident within five days as required by the Department.</p> <p>RESIDENT #119</p>	F 225	See Page 2	

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F 225	Continued From page 5 Similar findings were identified for Resident #119 who was observed with a bruise to her left wrist area on 05/15/13. There was no indication in the resident's record, or on the facility's Incident Log, that the bruise had been identified. In an interview on 05/20/13 at 2:04 p.m., Staff I observed the bruise and it measured at four centimeters (cm) by three cm. She then stated, "That should be monitored, especially for safety reasons." On 05/20/13 at 2:05 p.m. Staff J entered a note into the resident's record that read, "Bruises left posterior forearm 4cmx3cm from attempted IV insert by EMT's when she had a recent hypoglycemic episode...". Record review revealed the episode occurred on 05/09/13. Failure to investigate the cause of the bruise, given that it had not been identified or monitored, prior to determining the cause placed this resident at risk for unidentified abuse or additional injuries.	F 225	See Page 2		
F 247 SS=B	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide notification to two of two residents (#143 and #13) reviewed for roommate changes. This failure denied residents their right to be informed of roommate changes.	F 247 F 247	The facility will continue to provide notification to residents before the resident's room or roommate in the facility is changed. Resident # 143 – Has since discharged home. Resident # 13 – Has not had a roommate change since admit.		

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F 247	<p>Continued From page 6</p> <p>Findings include: Review of the admission packet stated "Residents are assigned to rooms based on availability, roommate compatibility and services required. Bethany makes a considerable effort to meet individual preferences and find compatible roommates and will work closely with the resident and family in resolving problems...Bethany will notify you before changing your room or roommate."</p> <p>RESIDENT #143 During an interview 05/16/13 at 9:17 a.m. Resident #143 stated that she had at least three different roommates since she was admitted less than a month ago. She stated "They did not tell me I was getting a roommate."</p> <p>RESIDENT #13 Similar findings were identified with Resident #13. In an interview on 05/16/13 at 9:45 a.m., when asked if she was given notice before a change in roommate she replied "No."</p> <p>In an interview 05/20/13 at 11:12 a.m. Staff H stated "We don't generally inform them (medicare residents) before a new roommate comes in. We try to put them in private rooms if we can. If there is a problem after one moves in then we look at what we can do...we try to make everyone happy."</p> <p>On 05/21/13 at 9:00 a.m. Staff H added "What would you suggest that we do? When I do let them know before (they get a roommate) they just ask more questions."</p> <p>In an interview 05/21/13 at 11:53 a.m. Staff F</p>	F 247	<p>Continued from page 6</p> <p>All residents will be notified prior to room or roommate change. Notification will be documented in the medical record.</p> <p>Nurse Managers will perform random audits to assure notification.</p> <p>Director of Nursing to ensure compliance.</p> <p>6/30/13 and Ongoing</p>		

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F 247	Continued From page 7 (Social Services Director) was asked about their policy regarding residents receiving notice before they get a new roommate. Staff F stated "I don't know what the policy states per se... between myself, nursing or admissions we do let the long-term care people know they are getting a new roommate." Staff F was asked what the facility did for the residents who were not considered long-term. She replied "It's very hard on the Medicare unit because of the turn over. It's not private. They know at some point they are getting a roommate... that would be almost impossible to do that for everyone on the short stay wing... the average stay is seven to ten days." In an interview on 05/21/13 at 1:15 p.m., Staff A reiterated it would be "impossible" to notify Medicare residents prior to their receiving a roommate due to the turn over on the rehab unit. She acknowledged the facility had not consistently provided advance notification once a roommate change was scheduled.	F 247	See Page 6		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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.	F 279	The facility will continue to develop, review and revise a comprehensive care plan for each resident. Resident #13 – The care plan has been updated to reflect resident's preference for female caregivers. Resident #107 – The care plan has been updated to reflect diet change and discontinuation of Hospice.		

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F 279	<p>Continued From page 8</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to revise comprehensive care plans for four (#s 13, 107, 172 & 88) of 29 residents reviewed. Failure to ensure care plans were accurate for caregiver preference, hospice care, diet orders, smoking and fluid restriction placed residents at risk for inadequate care or unmet care needs.</p> <p>Findings include: RESIDENT #13 Resident #13 admitted to the facility on [REDACTED] 13 with multiple medical conditions and [REDACTED]</p> <p>Record review revealed on 04/18/13 a care conference was held with staff, the resident, and the resident's power of attorney (POA). The resident stated she strongly preferred female caregivers due to past issues. The facility informed the resident and resident's POA they would do their best to accommodate the request.</p> <p>Review of the resident's Care Plan revealed no indication the resident requested only female</p>	F 279	<p>Continued from page 8</p> <p>Resident #172 – The care plan has been updated to reflect change in smoking habits.</p> <p>Resident #88 – Care plan has been updated to reflect discontinuation of fluid restriction and the sign posted in room has been removed.</p> <p>All Nurse Managers will be re-inserviced on updating care plans in a timely manner.</p> <p>Periodic audits of care plans will be done by Nurse Managers to assure care plans are updated with resident changes and preferences. Findings will be reviewed at monthly Continuous Quality Improvement Meetings.</p> <p>Director of Nursing to ensure compliance.</p> <p>6/30/13 and Ongoing</p>		

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F 279	<p>Continued From page 9 caregivers. Failure to include this information placed the resident at risk for frustration and emotional distress.</p> <p>On 05/20/13 at 10:00 a.m., Staff C, the Resident Care Manager, acknowledged direction to staff to provide female caregivers was not included in the care plan, but should have been.</p> <p>RESIDENT #107 According to the Resident Care Guide, dated 03/26/13, the resident was on [REDACTED] received a no concentrated sweets / diabetic diet, and if medication was refused three times, staff were to contact his family.</p> <p>Review of Interdisciplinary Team notes revealed Hospice was discontinued on 01/09/13 and his diet was changed to a "general" diet on 03/22/13. Neither of those changes were reflected in the care plan. In addition, in an interview on 05/21/13 at 12:50 p.m., Staff C stated staff no longer contacted the resident's family with each refusal, as they were aware he frequently refused. She acknowledged the care plan should have been updated to no longer include that direction to staff. She also acknowledged the hospice and diet changes were "missed" when the care plans were recently updated.</p> <p>RESIDENT #172 Similar findings were identified for Resident #172 whose care plan identified he "smoked daily" and included direction that while he preferred staff take him to the smoking area, the goal was for him to take himself to smoke.</p> <p>In an interview on 05/21/13 at 12:55 p.m., Staff C</p>	F 279	See page 8		

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F 279	Continued From page 10 stated the resident "only smoked once since he admitted a month ago" and that the care plan was inaccurate. RESIDENT #88 Similar findings were noted for Resident #88 for whom a sign posted in his room informed staff the resident was on a "Free Water Restriction 1000." However, a physician's order, dated 04/26/13, discontinued the restriction. The facility failed to ensure all plans of care were updated related to the resident's care.	F 279	See page 8	
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: Based on observation, record review and interview, the facility failed to consistently monitor the condition of Resident #119, one of three residents reviewed for non-pressure skin conditions and Resident #68, one supplemental resident with impaired skin. Failure to identify and accurately document the condition of residents' skin or to monitor and objectively measure wounds, placed these residents at risk for delayed healing and/ or the development of new wounds.	F 309	F 309 The facility will continue to 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. Resident #119 – A skin sheet was started for the bruise on the left wrist and has since resolved. Resident #68 – A skin sheet was started for the facial bruising and is currently being monitored. The facial bruising is almost completely resolved.	

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F 309	<p>Continued From page 11</p> <p>Findings include: Refer to: CFR 483.13(c)(3), F225, Investigate/Report Allegations</p> <p>In an interview on 05/21/13 at 10:35 a.m., Staff B, the Director of Nursing Services (DNS), stated the facility did not have a written policy specific to identifying and monitoring non-pressure related skin issues. She was then asked what the expectation was of staff if they were to see a bruise on a resident. She stated "If we don't know what it's from then there should be a skin sheet."</p> <p>The facility's "Wound/Skin Condition Evaluation Report" allowed staff to document various types of skin issues to include "Bruises." Along with the type of skin condition, staff were able to document other details such as the date, site, status, length/width and color.</p> <p>RESIDENT #119 Resident #119 was admitted to the facility [REDACTED]/13 after [REDACTED] of a [REDACTED] that had been infected. The resident also had care needs related to [REDACTED] and [REDACTED]. The 04/25/13 Minimum Data Set stated the resident had clear comprehension to understand and was understood by others.</p> <p>Initial observation of this resident on 05/15/13 at 11:20 a.m. revealed many small bruises to the resident's bilateral arms and one larger bruise to the left wrist area measuring approximately 2.5 centimeters (cm) by 2 cm. On this day there was no identification or monitoring found addressing the presence of the larger bruise.</p>	F 309	<p>Continued from page 11</p> <p>All Nursing Assistants will be re-inserviced on the expectations of reporting skin conditions to the Licensed Nurse.</p> <p>All Licensed Nurses will be re-inserviced on monitoring and documenting of skin conditions.</p> <p>Nurse Managers will audit skin books weekly.</p> <p>Director of Nursing to ensure compliance.</p> <p>6/30/13 and Ongoing</p>	

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F 309	<p>Continued From page 12</p> <p>In an interview 05/20/13 at 10:00 a.m. Staff I (the Resident Care Manager) stated "The nurse does the weekly skin assessment." She indicated that it would be expected of the Certified Nurse Assistant to inform the nurse if they noticed a skin issue during care. She went on to say "If it's a substantial bruise I would expect it to be on the skin sheet."</p> <p>Observation on 05/20/13 at 10:25 a.m. revealed the bruise to the left wrist appeared slightly larger than it had on 05/15/13. At that time Staff I indicated she was not aware of the bruise and was unable to locate any identification or monitoring of it.</p> <p>On 05/20/13 at 2:04 p.m. Staff I and J (Licensed Nurse) were at the bedside of the resident. The bruise to the left wrist area was measured at 4 cm by 3 cm by Staff J. Staff I stated "That should be monitored, especially for safety reasons."</p> <p>On 05/20/13 at 2:05 p.m., Staff J entered a progress note in the resident's record that stated, "Bruises left posterior forearm 4cmx3cm from attempted IV insert by EMT's when she had a recent [REDACTED] episode...".</p> <p>On 05/21/13 at 11:10 a.m. Staff B added staff "should have documented it somewhere and monitored it especially due to location and the delayed bruising process." She went on to say that this bruise should have been on a skin sheet so it could be properly monitored.</p> <p>RESIDENT #68 Similar findings were identified for Resident #68 for whom staff identified substantial facial bruising</p>	F 309	See page 11	

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F 309	Continued From page 13 following a fall, but failed to monitor the bruising to determine it's progression. In an interview on 05/21/13 at 3:15 p.m., Staff I stated Resident #68 was placed on "alert charting for laceration bruising" following a fall on 05/04/13, however there had been no measurements obtained or other objective monitoring of the bruises since that time.	F 309	See page 11		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that a resident who needed assistance with grooming activities was assisted. Failure to provide assistance to one (#289) of three residents reviewed for activities of daily living left the resident at risk for health complications associated with a lack of nail care, including skin breakdown, injuries, and infection. Findings include: RESIDENT #289 Resident #289 admitted to the facility on [REDACTED]/13, after being treated for a [REDACTED] The admission Minimum Data Set assessment dated, 05/10/13, indicated the resident required	F 312	F 312 The facility will continue to ensure that residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Resident #289 – Fingernails have been trimmed by nursing staff. Toenails were trimmed by the podiatrist. Hand soaks and nail care were added to the care guide. Nursing Assistants will be re-inserviced regarding nail care and reporting nail care issues to the Licensed Nurse.		

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F 312	<p>Continued From page 14</p> <p>extensive assistance with most activities of daily living, but only limited assistance with grooming activities. This assessment indicated the resident experienced moderate cognitive impairment.</p> <p>On 05/15/13 at 2:30 p.m., Resident #289 was observed lying in bed in a supine position, a bandage on the tip of her right finger. The resident's fingernails were observed to be elongated, approximately five to six centimeters, and in some instances curled around the end of the fingers tips. Several nails were jagged and broken. The resident reported the band aide on the right finger was covering a nail that recently broke. The resident's finger nails remained in the same condition during additional observations on 05/15, 16, 17 and 05/20/13.</p> <p>On 05/21/13 at 9:30 a.m., when asked if staff offered to assist her with nail care the resident reported "no". She then stated her fingernails kept breaking and indicated two broken nails that had been torn away from the nail bed on her right hand. The thumb nail on the left hand was elongated, thickened and curled around the tip of the thumb. The resident's spouse, who was present at the time, then commented her toe nails were in a similar condition and stated the toes were "sensitive."</p> <p>On 05/21/13 at 9:40 a.m., the Licensed Nurse, Staff D, was interviewed about nail care. When asked about Resident #289's nail care, she stated the nursing assistants "might be polishing and trimming the resident's nails." Staff D verified the resident was not diabetic and therefore did not require a specialist to provide nail care.</p>	F 312	<p>Continued from page 14</p> <p>Licensed Nurses will be re-inserviced on assessment of and appropriate referrals regarding nail care issues.</p> <p>Nurse Managers to monitor.</p> <p>Director of Nursing to ensure compliance.</p> <p>6/30/13 and Ongoing</p>		

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On 05/21/13 at 9:50 a.m., Staff K, a nursing assistant who identified as familiar with the resident and her care, commented the resident was not always a reliable historian. When asked about the resident's nail care, Staff K stated Resident #289 sometimes refused care. She was unable to state when she last offered, or provided, nail care. When asked about nail care on the resident's feet, Staff K stated, "I think she has a pending appointment with a podiatrist."

On 05/21/13 at 10:35 a.m., Staff E (who was acting as interim Resident Care Manager for this resident) observed the resident's nails. All of the toe nails were noted to be thickened and elongated. The nails were approximately five to six centimeters long. Some were observed to curl around the end of the toes, while others had grown at an angle and others appeared to have grown in layers at the end of the toes. The resident's spouse reiterated repeatedly the resident's feet were "sensitive."

Staff E acknowledged the resident needed assistance with nail care and stated her toe nails should be evaluated by a podiatrist. Staff E stated this was the first time she had heard anything about the condition of the resident's nails. When asked why the issue was not identified in the admission assessment, dated 05/03/13, she stated she did not know.

On 05/21/13 at 2:30 p.m., Staff E reported a podiatry consult had been arranged for the following week. She also stated hand soaks and nail care had been added to the care plan after a physician's order was obtained. She then provided a progress note, dated 05/21/13, that

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F 312	Continued From page 16 indicated the elongated nails were present at the time of admission. Failure to ensure Resident #289 received necessary nail care placed the resident at risk for health complications associated with overgrown nails, including untreated infections, skin breakdown and injuries.	F 312	See page 14		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	F 329 The facility will continue to ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Resident #214 – Behavior monitoring for sleep and anxiety has been implemented to evaluate the effectiveness and continued need for medications. Resident #205 – Sleep monitoring has been revised to include all sleep patterns in bed and in wheelchair to adequately assess effectiveness of medications.		

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F 329	<p>Continued From page 17</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to have a medication administration system which ensured each resident's drug regimen was free from unnecessary drugs for three of 10 residents reviewed for unnecessary medication use. The facility failed to ensure Resident #s 205 and 214 received adequate monitoring and/or had indications for use to ensure continued need of medications. The facility failed to conduct gradual dose reductions for Resident #107. These failures placed residents at risk for the use of unnecessary medications and harm from side effects.</p> <p>Findings include: POLICY The facility's policy indicated mood stabilizing medications would be implemented using the same guidelines as a psychoactive medication. The policy also directed staff to add behavior monitors associated with the psychoactive medications when they were implemented.</p> <p>RESIDENT #214 Resident #214 was admitted to the facility on [REDACTED]/13. During the survey the resident was observed to attend activities and meals, and staff provided stand by assistance with a walker. The resident was observed actively engaged in activities, socializing with others, and to sporadically nap.</p> <p>Review of physician's orders revealed the resident received two [REDACTED] medications related to a diagnosis of [REDACTED]. Both of these</p>	F 329	<p>Continued from page 17</p> <p>Resident #107 – Family care conference was held and Remeron has since been discontinued.</p> <p>The facility will continue to review psychoactive medication use and behavior monitoring at monthly Psychotropic Medication meetings.</p> <p>Nurse Managers will be re-inserviced on psychoactive medication need, behavior monitoring and gradual dose reduction.</p> <p>Random audits will be performed on psychoactive medication use and monitoring with findings discussed at monthly Continuous Quality Improvement meetings.</p> <p>Director of Nursing to ensure compliance.</p> <p>6/30/13 and Ongoing</p>	

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F 329	<p>Continued From page 18</p> <p>medications were implemented in January, after her admission to the facility. An [REDACTED] was administered for [REDACTED]" and an [REDACTED] medication was administered for [REDACTED] related to [REDACTED]"</p> <p>Although the two medications were administered to facilitate sleep and treat related [REDACTED] there was no evidence a behavior monitor had been implemented. On 05/22/13 at 9:30 a.m., Staff I reviewed the resident's record and verified neither a sleep monitor or anxiety tracking was in place. Staff I stated she did not know why there was no behavior monitor in place as she expected there to be one given the resident's use of medications. Failure to monitor behaviors left the facility without sufficient information to evaluate the effectiveness and continued need for the use of the two medications.</p> <p>RESIDENT # 205 Resident #205 was admitted to the facility in [REDACTED] 12 with multiple diagnosis including [REDACTED]. The resident's most recent Minimum Data Set assessment, dated 02/ 14/13, indicated the resident developed new behavioral symptoms that were displayed daily that included physical aggression directed towards others.</p> <p>During observations throughout the survey the resident was observed to remain seated in a wheelchair during the day time hours. At numerous time the resident was observed sleeping while seated in the wheelchair in his living unit, the common areas and the dining room.</p> <p>The resident's current medication orders included</p>	F 329	See page 17	

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F 329	<p>Continued From page 19</p> <p>three different [REDACTED] medications, an [REDACTED], an [REDACTED], and a [REDACTED] to assist with behavior management. The [REDACTED] medication was added on 04/02/13, to treat "sundowners." Physician's orders directed staff to monitor hours of sleep, which could be an adverse side effect of the medications.</p> <p>Review of the resident's clinical record revealed a [REDACTED] "Running Drug Use" form. It noted the resident had 18 changes in [REDACTED] medications since January, 2013. The document identified different medications and multiple changes in dosage as well.</p> <p>A mental health consult was obtained on 04/05/13. The psychiatric consultant's report recommended a dose reduction of the [REDACTED] medication. The clinician also commented that the length of medication trials made it difficult to determine the effectiveness of the medication interventions.</p> <p>On 05/22/13 at 9:50 a.m., the resident was observed sleeping in his wheelchair in front of the nursing station. The Resident Care Manager, who was in the area, was interviewed about the sleep monitor. When asked about the resident's sleep pattern, she stated staff did not document episodes of "sleeping" in the wheelchair. She commented the resident could be easily aroused so staff did not consider that "sleeping". She then called out to the resident to arouse him, but he continued to sleep and did not respond. The Licensed Nurse assigned to the unit who was in close proximity at that time verified the sleep monitor would only document the resident</p>	F 329	See page 17	

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F 329	<p>Continued From page 20 "sleeping" when in bed.</p> <p>The facility failed to ensure staff accurately monitored the resident's sleep pattern, which could be an adverse side effect of medications. Failure to accurately document hours of sleep left the facility without adequate information to assess the effectiveness to the medications being administered.</p> <p>RESIDENT #107 Review of Resident #107's record revealed he received ██████████ 7.5 milligrams since 08/12/11 with no changes. The Psychoactive Running Drug Use list noted no changes were made throughout 2012 as the resident was on hospice services. On 12/12/12 staff noted "No changes per family."</p> <p>Review of Target Behavior Monitoring revealed the resident occasionally was more anxious after family visits and declined to speak to family/staff. In addition, the resident frequently refused medications and blood sugar checks.</p> <p>In an interview on 05/21/13 at 12:50 p.m., Staff C stated the resident had a history of refusing medications and had experienced changes in his medical condition over the past year. She stated hospice services were discontinued in January 2013 as he had stabilized.</p> <p>In an interview on 05/22/13 at 10:20 a.m., Staff F, Social Services Director, stated the resident's family had previously not wanted any changes in his medication. She stated the facility had spoken to the family in the past, as last indicated by the 12/12/12 entry on the Drug Use list. She stated they thought the medication was working and so</p>	F 329	See page 17	

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F 329	Continued From page 21 were opposed to any changes. Staff F acknowledged the resident's behaviors, as monitored by the facility, were ongoing and consistent. Staff F stated the pharmacist recommended a GDR on 03/12/12 and noted the low dose was "most likely not affecting mood." The physician refused the reduction at that time, but had no evidence a prior reduction was attempted or failed. Failure to attempt a dose reduction for an anti-depressant placed the resident at risk to receive an unnecessary medication.	F 329	See page 17	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure foods were stored, prepared, served and distributed under sanitary conditions. Failure to ensure the dishwasher used to serve meals effectively sanitized the dishes placed all residents at risk for food borne illness. In addition, failure to ensure food preparation equipment was adequately	F 371	Bethany will continue to work with contracted provider to procure food from sources approved or considered satisfactory by Federal, State or local authorities; and store, prepare, distribute and serve food under sanitary conditions. Facility will ensure serving foods under sanitary conditions in the kitchen. <ul style="list-style-type: none"> Dish machine problem has been fixed and Test strips will now be performed daily and documented on temperature and test log sheet. Production area and other equipment will be cleaned on a regular basis. The broken/damaged commercial blender lid has been replaced. 	

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NAME OF PROVIDER OR SUPPLIER BETHANY AT PACIFIC		STREET ADDRESS, CITY, STATE, ZIP CODE 916 PACIFIC AVENUE 3RD-5TH FLOORS EVERETT, WA 98201		
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F 371	<p>Continued From page 22</p> <p>cleaned and that food was stored properly created the potential for food contamination for all residents receiving food prepared by the dietary department.</p> <p>Findings include: On 05/14/13 at 9:10 a.m., during the initial tour of the kitchen, the temperature gauges on the dish machine were observed. It was noted the wash temperature did not register and the rinse temperature read 160 degrees Fahrenheit (dF). Temperature requirements posted in the area indicated the rinse cycle needed to reach 180 dF to effectively sanitize the dishware. Dietary staff working in the area pointed out a log of temperature tests completed on the dish machine. The staff indicated they had just started the machine and that it may take a few minutes to reach the required temperature. The staff continued working in the area and running racks through the machine. Approximately ten minutes later, Staff M, Dietary Supervisor, accompanied the surveyor to the dish area. The gauges were observed to read the proper temperatures. Staff M used a test strip to test the temperatures of the rinse.</p> <p>The test was conducted twice and although the temperate gauges indicated the appropriate high temperature was reached, the test strips repeatedly showed the dish machine temperature was not hot enough to effectively sanitize the dishware. Staff M acknowledged the dish machine was not working correctly.</p> <p>On 05/17/13 at 12:30 p.m., a service technician was observed working on the dish machine. He reported he previously visited the facility on</p>	F 371	<p>Continued from page 22</p> <ul style="list-style-type: none"> Leaking refrigerator in pantry - Work order had been initiated prior to survey and has now been corrected. <p>Providence Food Service managers will monitor for compliance with supervision and ongoing in-services and Dietary Director to ensure compliance and report findings to CQI committee.</p> <p>Dietary Director to assure compliance.</p> <p>Compliance date: 6/30/13 and on-going</p>	

QJ.

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F 371	<p>Continued From page 23</p> <p>05/14/13 to make repairs to the dish machine. He stated the machine had a hot water booster that malfunctioned and therefore did not bring the rinse temperature to 180 dF.</p> <p>Staff L, Dietary Manager, stated the temperature gauge on the exterior of the machine was replaced on 05/14/13, and after that it was apparent the rinse temperature was not reaching 180 dF as required. Staff L reviewed the temperature log and verified a test using the strips had not been documented.</p> <p>On 05/21/13 at 11:20 a.m., Staff L provided a document showing the last test strip was completed on 05/07/13. Staff L stated it appeared staff were not documenting the test strips and verifying temperatures were appropriate. She stated staff had been asked to perform the test each day so the facility would know if something was wrong with the dish machine, but that "staff were not doing it." Staff L further stated the temperature appeared to be checked once a week.</p> <p>Documentation provided by the facility following the end of survey indicated the dish machine temperatures were checked every two to three days. While this form showed the temperature had been verified on 5/12/13, there was no indication of why this information had not been available to the Food Service supervisors when asked, or why they were not aware of the ongoing testing of the temperatures. In addition, there was no indication the dishwasher was tested on 05/13/13 so it was unknown when the malfunction in temperatures occurred.</p>	F 371	See page 22		

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F 371	<p>Continued From page 24</p> <p>In addition, during the initial tour of food preparation and storage areas on 05/14/13, the following were noted:</p> <p>The bases of a robo coup blender in a nourishment preparation area had dried food matter on the base and buttons that was visible. A commercial blender and food processor were observed in the same condition in the cook preparation area. The lid to the commercial blender had a top that was broken and damaged, making the item difficult to sanitize.</p> <p>The microwave oven next to the warming oven had food spills in the interior. Two can openers were observed mounted to the counter tops in the kitchen. Both had food spills on the base and blade.</p> <p>A refrigerator with a roll in cart had a sheet pan that over flowed with water when its contents were checked. The sheet pan was placed above ready to eat items that were not covered. The Dietary Supervisor, Staff M asked an unnamed diet aide about the sheet pan. She stated the water was leaking from a condenser in the refrigerator.</p> <p>Three metal bins that contained bulk dry goods, were found open. Approximately seven plastic bins were observed outside the dry storage area that had food matter spilled on the top and/or had dried food stuff on the handles.</p>	F 371	See page 22	
F 425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency</p>	F 425	<p>F 425 The facility will continue to clarify and follow Physician's Orders and ensure medications are administered as ordered.</p>	

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F 425	<p>Continued From page 25</p> <p>drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to: clarify and or follow Physician's Orders and ensure medications were administered as ordered for three of ten residents (#s 119, 107 & 120) reviewed for unnecessary medications. These failures placed residents at risk for untreated medical conditions and medication errors.</p> <p>Findings include: RESIDENT #119 Resident #119 was admitted to the facility [REDACTED] 13 after [REDACTED] wound that had been [REDACTED]. The 04/25/13</p>	F 425	<p>Continued from page 25</p> <p>Resident #119 – Licensed Nurses involved with administering the medications were interviewed and stated medications were given but not documented. Resident was interviewed and stated she removed the patches. Licensed Nurses involved were coached.</p> <p>Resident #107 – Oxycodone and Morphine orders have been discontinued. The resident is currently receiving Tylenol for pain. MAR has been corrected to clarify routine Colchicine. Pain assessment will be continued as needed. Care conference with family was held and family is in agreement with plan.</p> <p>Resident #120 – No longer resides at facility.</p> <p>Licensed Nurses will be re-instructed on the importance of following physician orders, timely documentation of medication administration and IV fluid documentation.</p>

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F 425	<p>Continued From page 26</p> <p>Minimum Data Set (MDS) indicated the resident had many active diagnoses to include high blood pressure.</p> <p>Record review of the physician orders in place since 04/18/13 revealed that this resident was supposed to receive [REDACTED] (a medication used to control [REDACTED] 50 mg (milligrams) every six hours. The Medication Administration Record (MAR) was blank for the administration of the [REDACTED] for the following dates and times: 05/12/13 at 11:00 p.m., 05/18/13 at 5:00 a.m. and 05/19/13 at 5:00 a.m.</p> <p>Staff I on 05/20/13 at 10:05 a.m. was asked about the blanks on the MAR. While looking through the record, Staff I stated "Doesn't look like they documented why. Looking at the blanks it looks like they forgot to sign it out...". Staff I acknowledged it did not look like the medication was given on those dates and times. On 05/21/13 at 9:55 a.m. went on to state "Typically that means it got missed."</p> <p>Similar findings for this resident were noted for the removal documentation of the [REDACTED] 5% [REDACTED] (a [REDACTED] to the [REDACTED] surface that can provide [REDACTED] f). The physician's orders stated to apply to the resident's lower back at 11:00 a.m. and remove at 11:00 p.m.. On the dates of 05/04/13, 05/05/13, 05/06/13, 05/07/13, 05/08/13, 05/09/13 and 05/10/13 the 11:00 p.m. entry on the MAR that was intended to document the removal of the patch was either blank, stated "N/A" or "not on." In an interview 05/21/13 at 9:25 a.m. Staff I stated "Hmm... I don't know what that means." The same day at 9:54 a.m. Staff I added "I can't tell</p>	F 425	<p>Continued from page 25</p> <p>The amount of IV fluids administered during each shift will be documented on the MAR.</p> <p>Nurse Managers will do random audits of MAR and findings will be discussed at monthly Continuous Quality Improvement meetings.</p> <p>Director of Nursing to ensure compliance.</p> <p>6/30/13 and Ongoing</p>	

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F 425	<p>Continued From page 27</p> <p>what happened. I've tried calling the nurses." Staff I indicated that it was unclear if the patch was removed as ordered by the physician.</p> <p>RESIDENT #107 Review of Resident #107's record revealed physician's orders for as needed (prn) doses of [REDACTED], [REDACTED] and [REDACTED]</p> <p>A 03/21/12 PO directed staff to "Give [REDACTED] first before other [REDACTED] per family request. If [REDACTED] given do pain assessment and chart why given."</p> <p>Review of the MAR revealed doses of prn [REDACTED] were administered on 04/08, 18, 22, 26, 29, 05/01, 04, 13, 14/13 for various indicators of pain.</p> <p>In an interview on 05/21/13 at 12:50 p.m., Staff C, Unit Manager, stated staff should attempt to give [REDACTED] prior to the [REDACTED], based on the order written at the family's request. She stated she thought staff gave the [REDACTED] as it was a liquid and therefore easier for the resident to swallow than a pill. She stated she did not know if a liquid version of [REDACTED] had been considered as she did not know if the facility would provide it. She stated the family could be asked if they wanted to provide it, but that had not been done.</p> <p>In an interview on 05/22/13 at 10:55 a.m., Staff C stated she had spoken to the resident's family and they had reiterated they did not want the [REDACTED] given and they expected the physician's orders to administer a [REDACTED] medication first would be followed.</p>	F 425	See page 25	

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F 425	<p>Continued From page 28</p> <p>The MAR included an 04/06/12 PO for [REDACTED] to be given twice a day for "for acute attacks only" of gout. Staff indicated the medication had been given routinely for over a year. In an interview on the morning of 05/22/13, Staff C stated the order was incorrect and the "for acute attacks" entry should have been removed.</p> <p>RESIDENT #120 Resident #120 was admitted to the facility in [REDACTED] with multiple diagnosis including [REDACTED]. Review of the 02/01/13 Significant Change MDS assessment indicated the resident experienced a decline in the ability to participate in activities of daily living and needed extensive assistance from staff to consume food and fluids.</p> <p>Review of physician's orders revealed on 01/25/13 an order was written to provide two liters of normal saline at a rate of 50 cubic centimeters (ccs) an hour intravenously (IV). The order expressly stated "no more than 2 liters of normal saline."</p> <p>Review of the MAR for January 2013 revealed fluids were infused during the day shift on 01/25/13, all three shifts on 01/26, 1/27, 1/28 and during the days shift on 01/29/13. The documentation did not identify how much fluid was infused each shift, however, according to the record IV fluids were provided for 88 hours. If the order for administration was followed as written, over four liters of normal saline would be administered in 88 hours.</p> <p>In an interview on 05/21/13 at 7:20 a.m., Staff B, the Director Of Nursing, stated staff did not usually document the amount of fluids delivered</p>	F 425	See page 25	

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F 425	Continued From page 29 each shift. She acknowledged the record showed the fluids were infused for 88 hours, which if delivered as ordered exceeded the two liters that had been ordered. Staff B, stated she believed the last entry on 01/29/13 during the evening shift was an error, however she was unable to explain how staff ensured the physician's order was followed.	F 425	See page 25	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431	F 431 The facility will continue to ensure drugs and biologicals are stored, labeled, dated and/or disposed of when expired in accordance with currently accepted professional standards and facility policy. All expired drugs and biologicals have been removed and disposed of from all medication rooms and medication carts. Staff on 4 th floor have been coached regarding key left in cabinet in clean utility room.	

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F 431

Continued From page 30
Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to ensure drugs and biologicals were stored, labeled, dated and/or disposed of when expired in accordance with currently accepted professional standards and facility policy. This failure placed residents at risk to receive expired medications and to have unauthorized access to medications.

Findings include:
THIRD FLOOR MEDICATION ROOM:
Observation on 05/14/13 at 9:52 a.m., revealed the following: a bottle of Geri-Tussin syrup, opened 08/12/11 with a manufacturer's expiration date of 02/13; a bottle of Calcium 600 milligrams with a manufacturer's expiration date of 05/11; Milk of Magnesia with a manufacturer's expiration date of 01/10; two boxes of accucheck plastic syringes with an expiration date of 09/22/12; 12 Packets of water that expired 01/09 and Gastrocult developer that expired 04/13.

THIRD FLOOR SOUTH MEDICATION CART:
Observation on 05/14/13 at 10:14 a.m., revealed a bottle of Vitamin E with an expiration date of 04/13. In an interview at that time, Staff D stated the above medications should have been disposed of.

F 431

Continued from page 30

Nurse Managers will routinely check medication carts and medication rooms for expired drugs and biologicals and utility rooms to ensure cabinets are locked and keys removed.

Findings will be reviewed at monthly Continuous Quality Improvement meetings.

Director of Nursing to ensure compliance.

6/30/13 and Ongoing

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F 431	Continued From page 31 FOURTH FLOOR MEDICATION ROOM: During initial rounds on 05/14/13 at 9:15 a.m. Vancomycin 250 mg/5mL was found in the refrigerator for Resident #172 with an expiration date of 05/10/13. House supply iron tablets were also observed with an expiration date of 06/12. Staff C (Resident Care Manager) stated that these two items "should be thrown out." FOURTH FLOOR CLEAN UTILITY ROOM: Also during initial rounds on 05/14/13 a box of Vitamin A and D Ointment was observed in a cabinet. The box stated "Keep out of reach of children." The cabinet had a key in it and was unlocked. A sign on the wall next to this cabinet stated to "Lock and remove the key." The clean utility was not locked and mobile residents were observed in the hallway.	F 431	See page 30		

DS.