

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

1305

PRINTED: 12/24/2013  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>505413 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>12/11/2013 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>COLONIAL VISTA CARE CENTERS | STREET ADDRESS, CITY, STATE, ZIP CODE<br>625 OKANOGAN<br>WENATCHEE, WA 98801 |
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| F 000 | <p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Colonial Vista Care Centers on 12/02/13, 12/03/13, 12/04/13, 12/05/13, 12/06/13, 12/09/13, 12/10/13 and 12/11/13. A sample of 31 residents was selected from a census of 62. The sample included 27 current residents and the records of 4 former and/or discharged residents.</p> | F 000 |  |  |
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Received  
Yakima RGS

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|  | <p>The survey was conducted by:</p> <p>██████████ RN<br/>██████████ RD<br/>██████████ RN<br/>██████████ RN<br/>██████████ RN</p> <p>The survey team is from:</p> <p>Department of Social &amp; Health Services<br/>Aging and Long-Term Support Administration<br/>Residential Care Services, District 1, Unit D<br/>3611 River Road, Suite 200<br/>Yakima, WA 98902</p> <p>Telephone: (509) 225-2800<br/>Fax: (509) 574-5597</p> <p><i>[Signature]</i><br/>Residential Care Services      Date 12/24/13</p> |  |  |  |
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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE<br><i>[Signature]</i> | TITLE<br>Administrator | (X6) DATE<br>1-3-14 |
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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 241<br>SS=E      | <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, interview and record review the facility failed to ensure 3 of 31 sampled residents (#40, 91 and 34) were treated with dignity. Failure to ensure prompt toileting as needed and accommodation of air freshners for room odors resulted in a reduced quality of life. Findings include, but are not limited to:</p> <p>Resident #40. Assessed on 09/11/13 as cognitively intact and frequently incontinent of urine. She was dependent on staff for transfers using a mechanical lift.</p> <p>On 12/09/13 at approximately 2:30 p.m., the resident stated this facility was the "last stop in life." She was wearing a skirt outfit, jewelry, and her hair was done professionally. The resident stated she frequently has had to wait approximately an hour before she could get help to the commode or to bed after dinner. Additionally, the resident did not want to sit on the commode too long or her "feet go dead." She noted her swollen leg. She stated that after a couple of minutes she needed transfered by a 'sit to stand' mechanical lift off the commode. She tried to tell the caregivers not to leave her room until she was done, but they go out anyway. It took time for them to return as they got busy.</p> | F 241         | <p><b>PREPARATION AND / OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OR 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 LAW.</b></p> <p><b>F 241 DIGNITY AND RESPECT OF INDIVIDUALITY</b></p> <p>1. The facility will re-assess resident # 40's toileting needs to include the possibility of utilizing a toileting schedule to better meet her toileting needs. The resident's care plan will also be reviewed and or updated as appropriate.</p> <p>Facility housekeeping staff and certified nursing assistants will have deodorizing sprays available to "freshen" resident #s 91 and 34's room following a BM (bowel movement). The facility has residents that are demented and wander in these areas of the facility. Making pressurized chemicals available to residents creates a potential safety concern from several standpoints. The first includes the possibility of ingesting or spraying chemicals into other individuals eyes and second, the cans are pressurized and under extreme heat will explode endangering the residents or others. Staff will keep these chemicals stored in a safe and secure area.</p> |                      |

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| F 241              | <p>Continued From page 2</p> <p>On 12/10/13 at approximately 9:45 a.m., the resident was sitting in the doorway of her room. She said she had had her call light on for awhile to use the commode so she could go to activities. She said "they keep coming by and saying they will be right back but aren't coming." At 9:55 a.m. two staff members went past resident #40 and informed her they would return and/or she would be helped soon.</p> <p>Resident #91. Admitted with multiple [REDACTED] injuries as a result of a [REDACTED] accident.</p> <p>On 12/04/2013 at 12:00 p.m., she stated in a slightly raised voice, "I am very upset." She stated the "head nurse" told her she could not have her own air freshner which she had had for six months. It was by Glade and the nurse aides sprayed it when she had a BM (bowel movement) and it smelled in her room. Resident #91 stated "they took it because they said it was a state law." When a second nurse came in and said she was going to take the spray away said she became upset and said "no you're not." The resident stated after that exchange the administrator came and said "I am not going to argue with you and we are going to take it whether you like it or not." She said it made her feel like it was not her home; the administrator had made her believe it was not her home and she had no rights in the matter. He was "very rude." Further she stated the staff did not attempt to find any solution to help her keep the spray safely in her room or find other ways to address the odor in her room.</p> <p>An anonymous caregiver stated the resident had three cans of nice air freshener in her room that she used for the smell of BM. The administration took it from all residents.</p> | F 241         | <p>2. Residents that have been identified as having incontinence care issues will be re-assessed for the possibility of being paced and a bowel and bladder re-training program to also include a toileting schedule if appropriate.</p> <p>Staff will keep all chemicals including any air fresheners used in safe, secure areas. Residents may request that their room be "freshened" following a bowel movement and staff will respond accordingly.</p> <p>3. Nursing and Housekeeping staff will be in-serviced on the appropriate use of deodorizes and air fresheners and that all cleaning chemicals must be kept secure and safe.</p> <p>4. The facility will interview residents and monitor their rooms for any odors occurring from bowel movements.</p> <p>5. Expected completing date will be January 24, 2014.</p> <p>6. The Housekeeping Supervisor and Resident Care Managers will be responsible.</p> | 1/24/14              |

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| F 241              | Continued From page 3<br><br>An anonymous caregiver stated the resident's air freshener was taken from her room "all of a sudden." She stated "the residents had room sprays for ever. The holiday sprays they had were nice, but all of a sudden this month they were banned." There was no attempt to place it on shelves or in drawers for protecting other residents if that was the "management's concern;" there "is no real wanderers to be concerned about." Resident #91 used hers for the BM smell in her room as she and her roommate don't go into the bathroom.   | F 241         |   |                      |
| F 279<br>SS=E      | Resident #34. On 12/11/13, the resident was out of the facility and unable to be interviewed.<br><br>An interview by an anonymous caregiver revealed the resident's spray air freshener was "stolen out of her room; Resident #34 thought the aide had stolen it." There was a "big deal" made out of it because of the resident's concern. The resident liked it for removing the smell of BM in her room.<br><br>On 12/11/13 at 9:45 a.m. Staff Member J stated that about a month ago, she removed the spray air freshener from the resident's room and stated the resident was sleeping at the time, then she was off shift. She said the resident became quite upset because she didn't know what happened to her air freshener. Staff Member J stated she talked with the resident the next day to explain why her spray was gone.<br><br>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's | F 279         |   |                      |

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F 279 Continued From page 4 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, the facility failed to develop a comprehensive plan of care for 2 of 3 residents (#40, 82) sampled for transfer pole use, 2 of 2 residents (#9, 163) sampled for hospice care and 1 of 3 residents (#9) sampled for urinary catheter care. Failure to develop a care plan with measurable objectives and timetables left these residents at risk of not attaining or maintaining their highest practicable physical, mental and psychosocial well-being. Findings include:

Transfer Pole Use:  
Resident #40. Admitted to the facility on [REDACTED]/07 with diagnoses including [REDACTED], [REDACTED], and [REDACTED]. Per the most recent comprehensive assessment dated 09/11/13 the resident required

F 279

**F 279 DEVELOP COMPREHENSIVE CARE PLANS**

1. The facility re-assessed the need and use of resident #'s 40 and 82's transfer pole use and evaluated the data collected to determine appropriate measurements of the transfer pole in relationship to the bed. The necessity of the pole was also documented in the medical record and the resident's care plans were updated to include how risks for entrapment could be mitigated. Maintenance staff also marked the floor area where the beds must be positioned in respect to the location of the transfer pole to avoid creating a potential entrapment hazard. Staff were also in-serviced on monitoring the appropriate location of the bed and the transfer pole and on entrapment risks and safety awareness. A safety plan of developed and accepted by the survey team during the survey.

The facility contacted the Hospice Providers for resident #'s 9 and 163 to obtain copies of their hospice care plans to integrate with the facility's care plans. The care plans will be reviewed to assure that the resident's care needs are being met and integrated with those of the Hospice providers.

Resident #9 will be re-assessed by licensed nursing staff and the care plan will be updated and revised to include urinary catheter care.

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| F 279              | <p>Continued From page 5<br/>extensive assistance for bed mobility and transfers.</p> <p>On 12/14/13 at approximately 3:00 p.m. a transfer pole (fixed pole from floor to ceiling) was observed approximately 10 inches away from the bed.</p> <p>Medical record review of an Equipment Assessment Form dated 12/03/12 revealed the resident had a transfer pole. The benefit of the transfer pole for the resident was evaluated to be enhanced mobility. The risk of using the transfer pole was identified as possible entrapment. The Equipment Assessment Form did not identify how the entrapment risk could be minimized.</p> <p>On 12/09/13 at approximately 3:00 p.m., Resident #40 stated she used the transfer pole to pull herself up in bed and her over bed light string and call light were attached to the transfer pole for her convenience. She stated it was very important for her to use the transfer pole to access assistance and pull herself up in bed.</p> <p>Review of the care plan dated 09/16/13 revealed Resident #40 required 1-2 people to assist her with bed mobility, and she used a side rail on her right and a transfer pole on her left to enhance her bed mobility. The care plan had no directives for safety with the use of the transfer pole or for placement of the bed in relation to the pole.</p> <p>Resident #82. The resident had diagnoses that included [REDACTED] disease and [REDACTED]. Per the comprehensive assessment, the resident required supervision with bed mobility and transferring from surface to surface.</p> | F 279         | <p>2. The facility will review or re-assess the use of all residents using transfer poles for positioning. The data collected will be analyzed to determine appropriate measurements of the transfer pole in relationship to the bed. Upon completing the assessment, the necessity of the transfer pole will be documented in the resident's medical record and the care plan updated or revised to reflect this assessment.</p> <p>The facility will also review all residents currently receiving hospice services from an outside hospice provider to assure that the hospice care plan is available and integrated with the facility's care plans.</p> <p>All residents currently with catheters will be reviewed to assure that urinary catheter care is care planned.</p> <p>3. Medical record audits will be conducted For 2 months to assure that transfer pole assessments are complete and documented in the medical record and care planned. Medical record audits will be conducted for all residents receiving hospice care to assure hospice care plans are in the medical record and integrated with facility care plans. Medical record audits will also be conducted for 2 months to assure that residents that have catheters are care planned as well.</p> |                      |

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| F 279 | <p>Continued From page 6</p> <p>Record review revealed an Equipment Assessment Form dated 02/14/13 and signed by Staff Member C, Licensed Nurse (LN). Staff Member C noted in the assessment form the transfer pole had a risk of entrapment. The form also documented "Steps taken to minimize risk: Transfer pole less than 2" from bed or greater than 24" from bed."</p> <p>Record review of the resident's care plan noted a goal she would "Transfer with supervision." The approach to accomplish that goal was to "Provide supervision for transfers using transfer pole." No other information was available in the care plan to guide staff in positioning the transfer pole safely.</p> <p>On 12/4/13 at approximately 9:00 a.m. the resident's bed was observed positioned away from the wall with the transfer pole 8" from the side of the bed.</p> <p>On 12/10/13 at 11:30 a.m. Staff Member F stated transfer poles should be 2" or 24" away from the bed and those measurements are on the consent form; however, she did not know if that specific risk management intervention was on the care plan.</p> <p>Failure by the facility to develop and implement a plan of care for safe use of transfer poles placed residents at potential risk of injury due to entrapment.</p> <p>Hospice:<br/>Resident #163. Admitted on [REDACTED]/13 with diagnoses including [REDACTED] and [REDACTED], and [REDACTED] care. The most recent assessment dated 11/04/13 indicated the resident had no problems with memory or decision making.</p> | F 279 | <p>Licensed nursing staff will also be in-serviced on analyzing transfer pole assessment data, determining appropriate positioning of the pole in respect to the bed location, documenting and care planning. Additional in-service education will be provided on assuring that hospice care plans are available in the chart and integrated with facility care plans and developing care plans for any resident that is receiving catheter care.</p> <ol style="list-style-type: none"> <li>4. Medical record audits will be forwarded to the facility's formal Quality Assurance / Performance Improvement Committee for review and / or further action.</li> <li>5. Expected completion date will be January 24, 2014</li> <li>6. The Director of Nursing, Staff Development Coordinator, and Resident care Managers will be responsible.</li> </ol> | 1/24/14 |
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| F 279              | <p>Continued From page 7</p> <p>Per review of the plan of care, Resident #163 was identified as having a [REDACTED] condition, noting the [REDACTED] that had spread to her [REDACTED]. The goal for this in the care plan was the resident would be provided with comfort measures, social support and her needs would be met. Among the approaches to meet this goal were: facility care plan to correlate with hospice care plan; hospice team to evaluate; hospice team to communicate to facility as needed and nursing to collaborate with hospice for symptom management.</p> <p>Review of the medical record on 12/06/13 found no plan of care developed by the hospice team.</p> <p>The in-room care directives were reviewed on 12/09/13 and identified the resident as independent with tasks of daily living. It also noted she required only stand by assistance with transfers (contrary to the care plan).</p> <p>Per observation on 12/09/13 at 12:30 p.m., Resident #163 was observed during a dressing change. She was unable to move independently of staff assistance at that time.</p> <p>On 12/09/13 at 12:50 p.m. Staff Member I, Nursing Assistant (NA) stated Resident #163 was weaker and needed much more care recently. When asked about the in-room care directives, she stated the in-room care plan was not up to date because the resident needed considerably more help now than she did.</p> <p>At approximately 4:30 p.m. on 12/09/13, Staff Member J, LN, verified the in-room plan of care did not accurately reflect the resident's current condition. She stated she had not updated the</p> | F 279         |   |                      |

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| F 279   | <p>Continued From page 8 directives.</p> <p>Resident #9. Admitted on [REDACTED]/13 with diagnoses including [REDACTED] and [REDACTED].</p> <p>Record review revealed that a Hospice program with an outside agency was initiated for Resident #9 on 11/09/13 due to [REDACTED] disease.</p> <p>Review of the resident's care plan with regard to her [REDACTED] care revealed a goal for resident to be provided with comfort measures, social support and needs will be met. One approach to meet this goal was "Facility care plan to correlate with hospice care plan." No care plan from the hospice agency was found in the medical record.</p> <p>On 12/06/13 at 1:10 p.m., Staff Member A, Director of Nursing Services (DNS), stated there was not a hospice care plan in the chart, but they would call Hospice and get a care plan faxed to the facility "right away."</p> <p>Failure by the facility to obtain and use the hospice plans of care did not allow the facility to correlate their care with hospice care as the care plan directed. Failure to keep the in-room care directives up to date may have denied the resident care appropriate to each resident's condition.</p> <p>Urinary Catheter Use:<br/>Resident #9. Admitted [REDACTED]/13 with diagnoses including [REDACTED] and [REDACTED]. Her most recent comprehensive assessment dated 11/14/13 noted she did not walk and required extensive assistance with toileting.</p> <p>Record review revealed a urinary catheter was</p> | F 279  |   |                      |  |

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| F 279              | <p>Continued From page 9 placed on 11/29/13.</p> <p>On 12/05/13 at approximately 5:30 p.m., Resident #9 was observed in her room in bed. A catheter bag was hanging from the bed.</p> <p>On 12/05/13 at 6:00 p.m., a representative of Resident #9 stated the catheter was placed because the resident could no longer get up and use the toilet, and because she did not like using an incontinent brief.</p>  | F 279         |   |                      |
| F 312<br>SS=E      | <p>Review of the resident's care plan for toileting and urinary continence had a goal that the resident "will be without odor or skin breakdown related to occasional urinary incontinence." The approaches to meet this goal were to provide 1 person extensive assistance for toileting in bathroom and to assist with changing brief. Urinary catheter care was not addressed.</p> <p>On 12/06/13 at approximately 1:10 p.m., Staff Member A, DNS, confirmed the care plan was the most recent plan they had for Resident #9. She acknowledged the care plan should include urinary catheter care and it did not. She stated the licensed nurse caring for the resident should have updated the care plan to include urinary catheter care when catheter use was initiated.</p> <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> | F 312         | <p><b>F 312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</b></p> <p>1. Resident #'s 5,50,49,45, and 91 oral care will be re-assessed and care plans for oral care will be updated and revised as appropriate. CNA staff will be directed to provide daily oral care to these residents.</p> <p>The facility will review resident #171's shower/bath schedule to assure that this resident is receiving baths or showers as scheduled or requested.</p> |                      |

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| F 312 | <p>Continued From page 10</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, interview and record review the facility failed to provide oral care for 3 of 3 residents (#5, 50 and 49) sampled and 2 supplemental residents (#45, 91) and a shower for 1 of 1 resident (#171) reviewed for Activities of Daily Living. This placed residents at risk for not attaining or maintaining their highest goal for physical and mental well-being. Findings include:</p> <p>Shower:<br/>Resident #171. The resident was admitted to the facility on [REDACTED]/13 from the hospital with multiple diagnoses that included [REDACTED].</p> <p>On 12/03/13 at approximately 7:45 a.m., the resident stated he had been in the facility about a week and no one had given him a shower yet. Further, he stated his back was "real itchy." He added the last time he showered was about 3 days prior to being admitted to the nursing home for a total of 9 days without a shower.</p> <p>On 12/03/13 at approximately 8:00 a.m. Staff Member E, a nursing assistant (NA) and Staff Member F, a licensed nurse (LN) both stated all residents are to be bathed on admission or the next day.</p> <p>On 12/05/13 at approximately 9:00 a.m., Staff Member B, the Regional Nurse stated the facility policy was to bathe residents sometime within 7 days of admit. However, Resident #171 "was not showered because no bath aides worked over Thanksgiving (11/28/13)."</p> <p>On 12/05/13 at approximately 9:15 a.m. Staff</p> | F 312 | <p>2. The CNA staff will be re-educated on providing daily oral care to residents. The Resident Care Managers will conduct daily rounds to assess and assure that resident's oral care is being provided.</p> <p>The bathing schedule will also be Reviewed or revised to assure that all residents are scheduled for showers or baths. Any resident not scheduled will be added and the Resident Care Managers will review the bath schedule daily to assure that residents received their scheduled showers or bath. Any scheduled bath or shower that is missed will be added to the next day's schedule. CNA's assigned to give baths will not be scheduled off on holidays to assure that baths are being provided as scheduled to include Holidays if appropriate.</p> <p>3. Please see # 2 Above.</p> <p>4. The medical records staff will conduct weekly audits of the bath Schedule for the next 60 days to assure that resident baths and showers are being provided as scheduled. Any further findings of missed baths will be submitted to the facility's QAPI Committee for further review and follow-up.</p> <p>5. Expected completion date will be January 24, 2014.</p> | 1/24/14 |
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| F 312              | <p>Continued From page 11</p> <p>Member G, a bath aide, stated she worked from 5 a.m. to 3:30 p.m. on Thanksgiving day "but Resident #171 was not on my bath list."</p> <p>On 12/05/13 at approximately 9:50 a.m., Staff Member H, NA, stated she worked on 11/28/13 and was assigned to Resident #171. However, she did not bathe him because his room was not on the shower schedule until the following Monday or Tuesday."</p>   | F 312         | 6. Resident Care Managers, Licensed Nursing staff, certified nursing assistants and Director of Nursing will be responsible. |                      |
|                    | <p>Oral Care:<br/>The facility's 'Routine Care Guidelines' revealed oral care was to be completed morning and evening and as needed.</p> <p>Resident #5. Diagnosed with [REDACTED] and [REDACTED]. The annual comprehensive assessment dated 10/23/13 noted the resident was cognitively intact and required total assistance for all activities of daily living, including oral care.</p> <p>The 10/23/13 care plan documented oral care be provided during the day and evening.</p> <p>On 12/03/13 at approximately 9:30 a.m., the resident was lying in bed and was unable to move without assistance. He stated he had staff brush his teeth for him. When asked how often he stated "at least twice a week" on morning shift. He added that the "evening shift doesn't get to it."</p> <p>On 12/05/13 at 10:45 a.m., the resident again stated he had his teeth brushed twice a week. His upper teeth, barely visible, were observed slightly brownish in color.</p> <p>Resident #50. Admitted with diagnoses including</p> |               |  |                      |

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| F 312   | <p>Continued From page 12</p> <p>██████████ and ██████████ and ██████████ pain. The 03/22/13 comprehensive assessment identified he was severely impaired cognitively. His functional status assessed a need for supervision by staff for his personal hygiene tasks that included brushing his own teeth.</p> <p>The care plan dated 09/18/13 noted he had natural teeth; he was to be set up at the sink twice a day to clean his teeth with cues required to stay on task. If needed, staff were to assist to complete tooth brushing.</p>   | F 312  |   |  |
|   | <p>On 12/04/13 at approximately 10:45 a.m., the resident's family member stated the resident was not getting his teeth brushed like he should. If the family was not there to provide the care, it would not be done; "they don't brush his teeth." The family member stated the resident had said that his "teeth were sticky." She stated the family came to visit daily but they "shouldn't have to" do his cares.</p> <p>Resident #49. Admitted with diagnoses including ██████████ injury, ██████████ and ██████████ injury. Per the comprehensive assessment she was totally dependent on staff for all dressing and personal hygiene activities.</p> <p>On 12/04/13 at approximately 10:20 a.m., Resident #49's representative stated she was at the facility every day to help care for Resident #49. She stated that the resident's mouth care was poor at times. She did not think her mouth was cleaned as often as it should be.</p> <p>On 12/04/13 at 10:45 a.m. Resident #49 was in bed. Her teeth appeared to be her own and they appeared to be a yellow-brown color.</p> |  |   |  |

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| F 312  | Continued From page 13<br><br>Review of the resident care plan revealed the resident had her own teeth and staff was to clean her mouth each shift.<br><br>On 12/06/13 at 11:35 a.m., Staff Member K, Nursing Assistant (NA), stated the expectation was to brush each resident's teeth every morning and evening, at a minimum.<br><br>Resident #45. Admitted with diagnoses including [REDACTED] disease and [REDACTED]. The 09/18/13 quarterly comprehensive assessment revealed she was cognitively intact and required extensive assistance with her personal hygiene, including brushing her teeth.<br><br>The 09/18/13 care plan documented a goal for the resident to remain clean and well groomed. She was noted to have natural teeth with directions for staff to set up the items for her to brush her teeth. Staff were to assist as needed to finish the task.<br><br>On 12/03/13 at 2:00 p.m. the resident stated the nursing assistants help set her up to brush her teeth about once or twice a week. "They work hard but they don't have time every day." The resident smiled to show broken and brown teeth.<br><br>Resident #91. Admitted with diagnoses of multiple [REDACTED] in the aftermath of a [REDACTED]. She was weak and unable to perform activities of daily living, including mouth care.<br><br>The 09/13/13 admission comprehensive assessment noted she was cognitively intact and required extensive assistance with personal | F 312   |   |   |

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| F 312              | Continued From page 14 hygiene.<br><br>The current care plan documented a problem with activities of daily living and a goal to remain well groomed and clean with set-up and assistance. The plan noted she had upper dentures and some lower natural teeth. Staff were to set up and cue her to clean her lower teeth and mouth assisting as needed for completion of the task. Staff were also to assist to clean her upper denture every morning and evening.   | F 312         |  |                      |
| F 315<br>SS=D      | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.<br><br>This REQUIREMENT is not met as evidenced by: | F 315         | <p><b>F 315 NO CATHETER, PREVENT UTI, RESTORE BLADDER</b></p> <p>1. Resident # 91 will be re-assessed for incontinence and their care plan revised and or updated as appropriate. The assessment will include the development of a toileting program if appropriate. Resident # 91's care plan will also be updated to reflect any changes or programs initiated for incontinence management or toileting. Upon completing the assessment, an appropriate diagnosis will also be obtained from the attending physician to support an incontinence management or toileting program.</p> |                      |

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| F 315              | <p>Continued From page 15</p> <p>Based on observation, interview and record review the facility failed to ensure toileting was provided per the assessment and care plan for 1 of 1 resident (#91) whose comprehensive assessment noted a decline in continence since her admit. This caused a decline in the resident's ability to remain continent of bladder and placed her at risk of health deterioration. Findings include:</p> <p>Resident #91. Admitted with multiple [REDACTED] injuries following a past [REDACTED]</p> <p>The [REDACTED]/13 admission comprehensive assessment noted she was admitted from another care facility. Through the assessment, it was determined she required total transfer assist with mechanical lift and was an extensive assist for toileting. She had occasional urinary incontinence and was using the bedpan rather than the toilet. One person assistance was needed.</p> <p>The 09/13/13 quarterly comprehensive assessment noted there was no trial and/or development of a toileting program and the resident was frequently incontinent (a decline in continence in the last three months). The active diagnoses did not indicate a problem that would cause incontinence. The resident was assessed as cognitively intact.</p> <p>On 12/04/13 at approximately 12:30 p.m., the resident was observed in her bed and stated she had waited two hours one morning for the bed pan; "they don't have enough staff." Usually she had to wait a half hour which was too long. Although she said day and evening shift was the hardest to get help on, she did not identify</p> | F 315         | <ol style="list-style-type: none"> <li>2. Residents triggering for incontinence will be reviewed to assure that they have an appropriate diagnosis to support an incontinence management program. These residents will be reviewed to assure that appropriate toileting programs are in place if applicable. Care plans will also be updated if needed to reflect these programs.</li> <li>3. Medical Records staff will conduct weekly audits for the next 60 days of residents triggering for incontinence to assure that appropriate diagnosis have been obtained to support incontinence management programs. Staff will also be re-educated on incontinence care programs and toileting residents timely.</li> <li>4. Medical record audit findings will be submitted to the facility's formal QAPI Committee for further follow up and review.</li> <li>5. Expected completion date will be January 24, 2014</li> <li>6. The Director of Nursing, Resident Care Managers, Licensed Nursing Staff, Certified Nursing Assistants, Staff Development Coordinator, Medical Records Supervisor will be responsible.</li> </ol> | 1/24/14              |

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| F 315   | Continued From page 16<br>specific times. She said "I pee my pants because I can't hold it...I want to use a bedpan for peeing but usually they are not here fast enough."<br><br>An anonymous staff member stated, when interviewed, the resident put her call light on when she needed to urinate. "If you don't get there in time, there is massive wetness and you have to change the bed. She does not hold her urine very long." The staff member stated s/he knew to "go quickly" when s/he saw the call light was on, but if s/he was in another room "who knows how long the light has been on."<br><br>An anonymous staff member stated the resident preferred a bedpan due to her condition. The resident had to wear incontinent pads now, she used to have just underwear. On evening shift, "it is not easy to get to her as fast. Especially after dinner when residents all want to go to bed."<br><br>An anonymous staff member stated it took too long for caregivers to get to the resident to put her on the bedpan. "She is aware and knows when she needs to urinate. They say she's incontinent but she's not. The staff are just not fast enough with her."<br><br>An anonymous caregiver stated Resident #91 can be kept dry if her light was answered in a timely manner. She was aware the night shift had kept the resident dry. | F 315  |   |                      |  |
| F 323<br>SS=D   | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives  | F 323  |   |                      |  |

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| F 323 | Continued From page 17<br>adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to ensure the resident environment remained as free from accident hazards as is possible. For 2 of 3 residents (#82, 40) sampled who used transfer poles at bedside, the facility failed to ensure the poles were positioned to minimize the risk of entrapment between the bed and the pole. Findings include:<br><br>Resident #82. Per the comprehensive assessment the resident had diagnoses including [REDACTED] disease and [REDACTED]. She required supervision with bed mobility and transferring from surface to surface, but was observed independently transferring from bed to chair on 12/04/13.<br><br>On 12/04/13 at approximately 9:00 a.m., Resident #82's bed was observed positioned in the middle of room. Neither side was against a wall. The bed wheels were in the locked position and the bed did not move when pushed. A transfer pole secured at ceiling and floor was observed approximately 2.5 feet from wall and approximately 8 inches from the side of the bed.<br><br>On 12/04/13 at approximately 4:00 p.m., Resident #82 stated she had used the transfer pole about one year. She stated physical therapy and nursing staff trained her on how to use the pole to transfer in and out of bed. During the interview, | F 323 | <b>F 323 FREE OF ACCIDENT/HAZZARDS/ SUPERVISION / DEVICES</b><br><br>1. Please see F 279 Plan of Correction | 1/24/14 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>COLONIAL VISTA CARE CENTERS |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>625 OKANOGAN<br>WENATCHEE, WA 98801                                    |                      |  |
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| F 323   | Continued From page 18<br>the transfer pole continued to be positioned approximately 8 inches from the side of the bed.<br><br>The resident's record review revealed an Equipment Assessment Form dated 02/14/13 and signed by Staff Member C, Licensed Nurse (LN). Staff Member C noted the transfer pole had a risk of entrapment. The form included additional notes - "Steps taken to minimize risk: Transfer pole less than 2" from bed or greater than 24" from bed."  | F 323  |   |                      |  |
|   | Review of the resident's care plan identified the resident used a transfer pole to enhance her ability to transfer out of or into her bed, but no documentation was found in the care plan with regard to the proper positioning of the pole in relation to the bed to decrease the potential risk of entrapment.<br><br>On 12/10/13 at 10:20 a.m., Staff Member D, Housekeeping, stated she cleaned resident rooms and often moved the bed and furniture to clean underneath them. She stated she cleaned Resident #82's room and had not been given any instruction about how to position the bed in relation to the transfer pole until last week.<br><br>Resident #40. Admitted to the facility on [REDACTED]/07 with diagnoses including [REDACTED], [REDACTED], and [REDACTED]. Per the most recent comprehensive assessment dated 09/11/13 she required extensive assist of 2+ caregivers for bed mobility and transfers. She was not able to balance when standing without staff assistance and used a wheelchair for locomotion.<br><br>Review of the most recent care plan identified Resident #40 required 1-2 people to assist her |  |   |                      |  |

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| F 323 | <p>Continued From page 19</p> <p>with bed mobility, and she used a side rail on her right and a transfer pole on her left to enhance her bed mobility. The care plan had no directives for safety with the use of the transfer pole or for placement of the bed in relation to the pole.</p> <p>On 12/04/13 at approximately 4:15 p.m., the bed in Resident #40's room was observed in mid room. A transfer pole was observed at the side of the bed, secured at the floor and the ceiling. The pole was positioned approximately 8 to 10 inches from the side of the bed. The brakes on the bed were locked.</p> <p>On 12/09/13 at approximately 3:00 p.m., Resident #40 stated she used the transfer pole to pull herself up in bed. She stated it was very important for her to use the transfer pole to access assistance and pull herself up in bed.</p> <p>Review of the resident's medical record revealed an Equipment Assessment Form dated 12/03/12. The form documented Resident #40 had a transfer pole and risk of entrapment was identified. There was no evaluation present in the form of how the risk of entrapment might be minimized or how to implement safety awareness of the transfer pole into the plan of care.</p> <p>The facility identified a risk of entrapment was associated with the use of transfer poles, but failed to evaluate how that risk could be mitigated. Failure by the facility to maintain the transfer poles in a position that minimized the risk of entrapment and implement safety awareness training among staff placed residents at risk of injury if they should fall between the transfer pole and their bed.</p> | F 323 |  |  |
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| F 329<br>F 329<br>SS=D | <p>Continued From page 20</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on interview and record review the facility failed to ensure quantitative monitoring for 1 of 5 residents (#153) reviewed who received antipsychotic medications. This failure impaired staff's ability to determine the effectiveness of medications used for behavior management and placed the resident at risk for adverse side effects and the use of unnecessary drugs. Findings</p> | F 329<br>F 329 | <p><b>F 329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b></p> <ol style="list-style-type: none"> <li>1. The facility will review resident #153's medication administration record (MAR) and initiate daily monitoring of the resident's target behavior. This will also include initiating a behavior management plan and behavior tracking form for this resident to support continued use of antipsychotic medications for treatment. Resident # 153's care plan will also be updated and revised to reflect the monitoring of this residents' target behaviors and the effectiveness of the medication used.</li> <li>2. A review will be conducted of all residents that are triggering for antipsychotic medication use to assure that a behavior management plan is in place as well as a behavior tracking form to monitor the effectiveness of this medication and whether target behavior goals have been reached.</li> <li>3. Licensed nursing staff will be re-educated on the use of antipsychotic medications and daily monitoring and documenting behaviors on behavior tracking form in an effort to determine whether these medications are effective in managing target behaviors.</li> </ol> |                      |

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| F 329 | Continued From page 21 include:<br><br>Resident #153 was admitted to the facility on [REDACTED]/13 with diagnosis of [REDACTED] in the [REDACTED]. The current comprehensive assessment indicated the resident had [REDACTED] impairment and exhibited behaviors towards others daily. Record review revealed a Behavior Management Plan dated 10/18/13 listing the resident's target behaviors as "potentially harmful restlessness: throwing legs out of wheel chair or bed" and "agitation that can escalate into combativeness i.e. pinching, hitting with cares".   | F 329 | 4. Medical record staff will conduct Weekly audits for 60 days to assure that the resident has a behavior management plan and behavior tracking form in place. They will also audit documentation to assure that licensed nursing staff are documenting daily monitoring of the use of antipsychotic medications. |         |
|       | Review of the December 2013 physician orders revealed the resident received [REDACTED] 0.25 milligrams (mg) daily (a medication used to treat [REDACTED] and other [REDACTED] and [REDACTED] conditions) at bed time for agitation due to [REDACTED].<br><br>Review of the October and November 2013 Medication Administration Records (MAR) revealed the resident had an additional order for [REDACTED] 0.25 mg as needed every 6 hours for [REDACTED] between 10/14/13 and 11/22/13. The resident received the medication 8 times for "increased [REDACTED]." Additionally, [REDACTED] 5 mg (a medication to treat [REDACTED] disorders) was ordered every eight hours as needed for agitation. Review of the October MAR revealed [REDACTED] was given 9 times between 10/08/13 and 10/13/13 for agitation and discontinued on 10/15/13.<br><br>Review of the care plan dated 10/17/13 for Psychosocial well-being identified the resident had restlessness and (was) combative with cares with the goal "will respond to intervention with decreased behaviors to less than daily." |       | 5. Expected completion date will be January 24, 2014.<br><br>6. The Director of Nursing, Staff Development Coordinator, Resident Care Managers and licensed nursing staff will be responsible.  | 1/24/14 |

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| F 329              | Continued From page 22<br>However, no daily monitor of the resident's target behaviors was found on record review.<br><br>On 12/05/13 at 5:45 p.m. the Director of Nurses stated residents on antipsychotic medication would have a behavior management plan and target behavior tracking forms in the resident's MAR. She added that Resident #153 should have both because he was on [REDACTED].   | F 329         |   |                      |
| F 333<br>SS=D      | On 12/05/13 at 6:10 p.m. Staff Member B, Regional Nurse, reviewed Resident #153's record and stated she could not find a target behavior monitor anywhere in his record.<br><br>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS<br><br>The facility must ensure that residents are free of any significant medication errors.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review the facility failed to ensure 1 of 4 residents (#21) sampled were free of significant medication errors. This failure placed the resident at risk for health related complications. Findings include:<br><br>Resident #21 was admitted to the facility on [REDACTED]/13 with diagnoses including [REDACTED]<br><br>Record review revealed a physician's order dated 04/25/13, from the hospital, for [REDACTED] 1000 milligram (mg) tablet (a seizure medication) give 1 tablet twice a day. The December 2013 Medication Administration Record (MAR) and the December 2013 physicians orders recap read | F 333         | <p><b>F 333 RESIDENTS ARE FREE OF SIGNIFICANT MED ERRORS</b></p> <ol style="list-style-type: none"> <li>1. The facility will review resident # 21's medication administration record and compare to the physician orders for accuracy. A medication error report was completed and the MAR will be corrected to reflect the correct order and dosage. The resident's care plan will also be updated to reflect the correct order of this medication being used.</li> <li>2. The Medical record staff will review all resident MAR's and physician orders to assure accuracy. Any incorrect orders on the MAR will be corrected to correspond with the physician orders.</li> <li>3. Medical Record staff will review the</li> </ol> |                      |

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| F 333   | Continued From page 23<br>██████████ 500 mg tablet give 1 tablet twice a day for ██████████<br><br>On 12/03/13 at approximately 8:44 a.m. during the medication pass observation, Staff Member F, Licensed Nurse (LN) administered 1 tab of ██████████ 500 mg. The monthly medication pack pharmacy label read ██████████ 500 mg tablets give two tablets (1000 mg) two times daily for seizures. The LN stated the resident's medication package was labeled with the wrong dosage. "I am following the directions that are on the December MAR."   | F 333  | month end physician recapitulation with the physician orders for accuracy and make any necessary changes to accurately reflect the physician orders.<br><br>4. Medical record staff will conduct month end physician recapitulation audits to ensure accuracy of orders. The facility will also notify the pharmacy that they need to fill the correct dosage with medication orders. The facility will so review this with it's consultant pharmacist when doing monthly medication regimen reviews. |                      |  |
| F 428<br>SS=D   | On 12/04/13 at approximately 5:00 p.m. The Regional Nurse stated that Staff Member F, LN had made a medication error. The resident should have been administered 2 tablets of ██████████ 500 mg (1000 mg) twice a day not 1 tablet twice a day. The resident's medication package did contain the correct ██████████ dosage. She added we have a new computer system in place "so on the first of September of this year the medical record staff entered the wrong ██████████ medication dosage onto the resident's MAR and Physician Recap Orders." Hence, the resident received the wrong ██████████ dosage for the past 3 months.<br><br>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON<br><br>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. | F 428  | F 428 DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON<br><br>1. The facility will follow up on and address the consultant pharmacy recommendations made for resident #'s 50 and 11.   | 1/24/14              |  |

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| F 428              | <p>Continued From page 24</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on record review and interview the facility failed to act upon pharmacist recommendations for 2 of 5 residents (#50, 11) reviewed for unnecessary medication. Failure to ensure that the pharmacist recommendations were acted on placed the residents at risk for possible adverse medication side effects. Findings include:</p> <p>Resident #50. The resident was admitted with diagnoses including [REDACTED] disease and [REDACTED] disorder with [REDACTED].</p> <p>The Pharmacist drug regimen review report dated 09/13/13 documented the pharmacist recommended the following: "increase in [REDACTED] due to behaviors during [REDACTED] [REDACTED] infection)- please review continued need."</p> <p>Review of the August 2013 physician orders revealed Resident #50 had an order for [REDACTED] 25 milligrams (mg) once a day and on 08/26/13 a new order to increase the dose to 25 mg twice a day due to an increase in behavioral outbursts.</p> <p>Record review revealed the resident was diagnosed and treated for a [REDACTED] on 08/30/13 (four days after the antipsychotic medication increase).</p> <p>Per review of the resident's record, the facility's response to the pharmacist's recommendation could not be found.</p> | F 428         | <p>2. The facility will review consultant Pharmacist recommendations for the past 90 days to assure that other pharmacy recommendations made for other residents were not missed.</p> <p>3. Licensed nursing staff will be re-educated on following up on consultant pharmacist recommendations in a timely manner with attending physician to assure that residents are not receiving any unnecessary medications.</p> <p>The Director of Nursing will also review the completed follow up recommendations to assure that licensed nursing staff addressed these recommendations with the attending physician.</p> <p>4. Monthly audits will continue to Be conducted by the consultant pharmacist in determining how many of her recommendations were acted on by the attending physician. This audit report will be presented to the facility's QAPI meeting for further review and or follow up.</p> <p>5. Expected completion date will be January 24, 2014.</p> | 1/24/14              |

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| F 428 | <p>Continued From page 25</p> <p>On 12/10/13 at 9:20 a.m. the Director of Nurses stated she kept the pharmacist drug regimen reports in a binder and the communications to the physician were placed in the resident's chart after completed. She stated she could not find documentation that the pharmacist recommendation had been addressed.</p> <p>On 12/10/13 at 9:25 a.m. Staff Member B, Regional Nurse, confirmed the pharmacist recommendation from 09/13/13 was not completed.</p> <p>Resident #11. The resident had diagnoses including [REDACTED] and [REDACTED] disease.</p> <p>The pharmacist drug regimen review dated 08/04/13 recommended the order for [REDACTED] (a medication to control blood sugar) include "give with food or a meal" and the order for [REDACTED] (a medication to treat heartburn) include "give within 30 minutes to 1 hour of meal".</p> <p>Per record review of the December 2013 physician orders and medication administration record, the orders for [REDACTED] and [REDACTED] did not reflect the pharmacist's recommendation nor was there documentation in the chart that the physician was notified.</p> <p>On 12/09/13 at approximately 3:10 p.m. Staff Member M, a licensed nurse, stated she gave Resident #11 her medications any time between 3:00 p.m. and 5:00 p.m. and she was not aware of any special administration instructions for either the [REDACTED] or [REDACTED].</p> <p>On 12/10/13 at at approximately 8:05 a.m. Staff</p> | F 428 | 6. The Director of Nursing, Licensed Nursing Staff, Resident Care Managers and Consultant Pharmacist will be responsible. |  |
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| F 428              | Continued From page 26<br>Member N, a licensed nurse, stated he was not aware of any special administration instructions for either the [REDACTED] or [REDACTED]<br><br>Interview on 12/10/13 at 10:00 a.m., the Director of Nurses stated the pharmacist recommendation for Resident #11 dated 08/04/13 were not addressed by nursing staff. | F 428         |   |                      |
|                    |   |               |   |                      |