

1309

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505278	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/31/2013
NAME OF PROVIDER OR SUPPLIER HEALTH AND REHABILITATION OF NORTH SEATTLE			STREET ADDRESS, CITY, STATE, ZIP CODE 13333 GREENWOOD AVENUE NORTH SEATTLE, WA 98133	
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Health and Rehabilitation of North Seattle on 12/12/13, 12/16/13, 12/30/13 and 12/31/13. A sample of 6 residents were reviewed for care from a census of 77. The sample included 4 current and 2 former residents.</p> <p>The following complaint was investigated as part of this survey: 2910995; 2913869; 2913432; 2916730; 2916776; 2916877; 2916894; 2916399; 2905692</p> <p>The survey was conducted by: [REDACTED], MN, R.N.</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 C Creekside Two 20425 72nd Avenue South, Suite 400 Kent, WA 98032-2388</p> <p>Telephone: (253) 234 6003 Fax: (253) 395 5071</p> <p><i>[Signature]</i> 1-8-2014 Residential Care Services Date</p>	F 000	<p>DISCLAIMER CLAUSE</p> <p>PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE THE PROVIDER'S ADMISSION OF OR AGREEMENT WITH THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW.</p>	1-21-14

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* (X6) DATE 1-17-14

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 250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide medically related social services to attain the highest practicable physical wellbeing for two of 6 residents (#1, #5) reviewed for care from a census of 77 residents. Failure to assist residents and/or resident decision maker cope with difficult treatment choices potentially contributed to weight loss and dehydration for Resident #1 and ongoing agitation, medication refusal and treatment non-compliance for Resident #5.</p> <p>Findings include:</p> <p>RESIDENT #1: Observation 12/12/13 at 12:45 p.m. found Resident #1 lying in bed in his room. A tube feeding machine was infusing. Resident #1 was unresponsive to call or touch.</p> <p>Record review found that Resident #1 was admitted to the facility [REDACTED]/12 with medically disabling conditions related to [REDACTED] injury. Resident #1's assessment and care plan identified the resident was totally dependent on staff for care. Health care decisions were made by his power-of-attorney (POA) as the resident</p>	F 250	<p>F250 Cited Residents The facility has re-approached to assist resident #1's POA and resident #5 understand and process treatment options in light of their serious medical conditions.</p> <p>Other Residents The facility has audited residents who have made an informed choice to refuse care/ treatments and has re-educated them to help assist understand and process treatment options in light of their serious medical conditions.</p> <p>System Review/Education The Interdisciplinary team has been in-serviced on how to assisted residents / POA's to understand and process treatment options in light of their serious medical conditions.</p> <p>Monitoring Audits have been done of residents who have made an informed choice to refuse care / treatment to make sure the facility has assisted them to understand and process treatment options in light of their serious medical conditions and this will be</p>	1-21-14

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F 250	<p>Continued From page 2 was not able to communicate his wishes.</p> <p>Medical records documented that twice in 6 months [REDACTED]/13 and [REDACTED]/13 Resident #1 was admitted to the hospital with critically high [REDACTED] levels, indicating [REDACTED]. On each occasion, a feeding tube was inserted. Medical records documented Resident #1 was unable to drink enough free water to maintain hydration without a feeding tube.</p> <p>Progress notes documented starting 4/9/13 the received only fluids (not nutrition) through the feeding tube at the request of the POA. Notes documented on 8/26/13 Resident's #1's feeding tube fell out and was left out at the request of the POA.</p> <p>Nutrition notes documented Resident #1's POA was educated on risks and benefits but continued to insist on oral feedings and regular texture foods, even though Resident #1 was not able to take in adequate amounts of food and fluid. Record review found no parameters or plan developed to ensure Resident #1 received the nutrition and hydration he required.</p> <p>Nutrition notes from April to September 2013 documented Resident #1 was not ingesting enough calories to maintain his weight, even with the addition of nutrition enhanced meals and calorie supplements. Nutrition records dated 9/24/13 documented Resident #1 had significant weight loss due to the resident relying solely on oral intake to meet nutrition needs.</p> <p>Social service notes did not document discussions or assistance to Resident #1's POA to help develop an individualized plan to maintain</p>	F 250	<p>reported to the CQI committee for the next three months to review for further educational opportunities.</p> <p>Responsibility The Administrator will be responsible for the ongoing compliance</p>	

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F 250	<p>Continued From page 3</p> <p>Resident #1's hydration and nutrition.</p> <p>On interview 12/10/13 at 10:05 a.m. Resident #1's POA stated she thought that Resident #1 was not taking in adequate amounts of food and fluid because staff do not feed or offer fluids properly or consistently, in a dignified manner.</p> <p>On interview 12/19/13 at 12:45 p.m. the consultant registered dietician (RD) for the facility stated she knew Resident #1 consumed less food/fluid than was offered and the POA had been repeatedly educated as to risks/benefits of this. The RD stated staff was honoring resident choice to refuse care, including meals and hydration.</p> <p>On interview 12/27/13 at 1:00 p.m. Staff J (social services) stated she had been focused on talking to Resident #1's POA about Resident #1's cognition level and deferred to speech and occupational therapy to explain treatment options.</p> <p>RESIDENT #5: Record review found Resident #5 was admitted to the facility [REDACTED]/13 with altered [REDACTED] status, [REDACTED] disorder, [REDACTED] and [REDACTED] ([REDACTED] disease caused by [REDACTED] failure).</p> <p>Resident #5's minimum data set (MDS) assessment dated 10/1/13 identified the resident was totally dependent on the assistance of 1-2 persons for all activities of daily living. The resident was incontinent of bowel and bladder. The resident's brief interview for mental status (BIMS) score was 9 indicating moderate cognitive impairment. The MDS identified Resident #5</p>	F 250		

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F 250	<p>Continued From page 4</p> <p>rejected care almost every day. Resident #5's care plan included basic interventions for care refusal.</p> <p>Treatment of hepatic encephalopathy options include taking the medication [REDACTED]. This medication is given to prevent intestinal bacteria from creating ammonia which can build up in the blood and affect the brain. [REDACTED] is a laxative used to remove blood and ammonia from the intestines.</p> <p>http://www.nlm.nih.gov/medlineplus/ency/article/000302.htm. Persons taking [REDACTED] for liver failure may have multiple bowel movements/day to maintain normal blood ammonia levels. It is difficult treatment due to the frequency of bowel movements and lack of control. Untreated hepatic encephalopathy can lead to coma or death.</p> <p>Medication record review found Resident #5's was prescribed [REDACTED]. This most recent order was for [REDACTED] 40 grams four times daily to ensure 2-3 soft bowel movements per day.</p> <p>Progress notes document Resident #5 persistently and almost daily refused one or more doses of [REDACTED] documented as starting around 10/10/13. Refusals were often accompanied by angry outbursts, swearing and/or shaking his finger, fist or silverware at staff. The resident was sent to the hospital 10/26/13 and 11/9/13 due to persistent refusal to take [REDACTED]. Record review found that since admission, Resident #5 refused daily restorative care. Review of Social Service notes found no documentation in any social service note addressing Resident #5's care refusals.</p>	F 250			

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F 250	<p>Continued From page 5</p> <p>Observation 12/12/13 at 10:05 a.m. noted Resident #5 yelling out as he was moved to a stretcher by medical transport personnel to attend a scheduled appointment. The resident said he would not go. Resident #5 called staff a liar when approached with information.</p> <p>On 12/16/13 at 12:45 p.m. Resident #5 was observed lying in bed. The resident said "Staff don't listen, (staff) hurt during care then say 'I don't hurt you'." Resident #5 said "It's mostly painful when (staff) turn and clean, they straighten and open my legs. I poop like a freight train! (A) lady said I don't have to take it (the medication). If this is what I have to endure, I don't want it.... The nurse said I'm a liar! They lie to me!"</p> <p>Staff documented talking about risks and benefits of taking medication but there was no indication in the record that staff addressed side effects of the medication and quality of life.</p> <p>On interview 12/10/13 at 5:15 p.m. Resident #5's doctor said the resident needed a guardian or POA to advocate for end-of-life care. The doctor said he asked nursing staff about it. "Nursing said it costs money to get a guardian."</p> <p>On interview 12/16/13 at 1:42 p.m. Staff A (resident care manager) stated there needed to be a discussion about the resident's resuscitation request and quality of life. There was no indication that these conversations had taken place with Resident #5.</p> <p>On interview 12/16/13 at 2:00 p.m. Staff K (social services) stated nurses educate Resident #5 on the risks and benefits of taking the medication.</p>	F 250		

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F 250	Continued From page 6 Staff K said her interaction with the resident included engaging the resident in conversation, talking about sports and she brings the resident butterscotch candy which the resident liked. Staff K said nursing and the doctor would tell her if there needed to be a discussion about treatment options and possible end-of-life or quality of life care. The facility failed to assist Resident #1's POA and Resident #5 understand and process treatment options in light of their serious medical conditions.	F 250	F-280 Cited Resident Resident #1 and Resident #2 nutritional care plans has been reviewed and revised to reflect their current nutritional status. The nutritional care plans include but are not limited to interventions to help prevent significant weight loss and dehydration.		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	Other residents The care plans for other residents who have had significant weight loss or have a condition that puts them at risk for significant weight loss have had their care plans reviewed and up dated. Education/Systems Review The Interdisciplinary Team has been in-serviced on revising the resident's care plans when there are changes in the resident's status. This status is to include weight loss. Monitoring The DNS or other appropriate nurse will audit the care plans on admission, quarterly and with change of condition to validate that the care	1-21-14	

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F 280	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed develop plans of care to maintain acceptable parameters of nutritional status for 2 of 6 residents (#1, #2) reviewed for care from a census of 77. This resulted in significant weight loss and dehydration for both residents. Findings include: RESIDENT #1: Record review found that Resident #1 was admitted to the facility [REDACTED]/12 with medically disabling conditions related to [REDACTED] injury. The resident's condition was not [REDACTED] Health care decisions were made by his power-of-attorney (POA). Resident #1's minimum data set (MDS) assessment dated 10/10/13 identified the resident was not able to participate in cognitive testing and had rejection of care behavior 4-6 days of the past seven days. Medical records documented that twice in 6 months ([REDACTED]/13 and [REDACTED]/13) Resident #1 was hospitalized with critically high [REDACTED] levels (166 & 162, normal range 135-145) indicating dehydration. A feeding tube was inserted on both occasions. Medical records documented Resident #1 was unable to drink enough free water to maintain hydration without a feeding tube. Nutrition and progress notes from April to November 2013 documented Resident #1's POA	F 280	plans are an accurate reflection of the residents needs. Results of the audits will be forwarded to the Quality assurance committee for 3 month to review for further educational opportunities. Responsibility The Director of Nursing will be responsible for the ongoing compliance		

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F 280	<p>Continued From page 8</p> <p>directed that Resident #1 was not to receive nutrition through his feeding tube as she thought Resident #1 was overweight and weight loss was desirable. Progress notes documented on 8/26/13 Resident #1's feeding tube came out and was left out at the request of his POA.</p> <p>During the time the POA was directing no tube feeding, or no feeding tube, the consultant registered dietitian (CRD) documented concern for malnutrition and ongoing significant weight loss (up to 23% documented 9/24/13) due to the resident relying solely on oral intake to meet nutrition needs. The CRD documented Resident #1 was not able to consume adequate calories, even when fed 1:1 by staff and using high calorie supplements.</p> <p>Resident #1's care plan updated every 2-3 months (from 1/17/13, last 11/21/13) identified the resident had chewing problems, cognitive issues, swallowing problems, required mechanically altered diet and was consuming less than 50% of his meal. Goals of care were to have no unplanned significant weight loss or gain, consume an unspecified percentage of meals, tolerate meal texture as ordered and consume more than 75% of fluids provided at meals. Staff was to offer liquids between meals (unspecified amount) and is eats less than 50% offer substitute or supplement (unspecified amount).</p> <p>Record review found no identified plan around goal of weight loss or minimum calories required to ensure controlled gradual weight loss. No additional interventions were developed to address weight loss or specific measurable interventions to meet Resident #1's nutritional and fluid needs. The CRD identified Resident</p>	F 280			

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F 280	<p>Continued From page 9</p> <p>#1's weight loss as unavoidable due to the POA, not Resident #1's medical condition "(POA) insisted that resident receive regular textured foods despite inadequate oral intake at meals." There was no identified plan to ensure Resident #1 was ingesting adequate fluids every day.</p> <p>On interview 12/19/13 at 12:45 p.m. the CRD stated facility practice of offering 1560 cc with meals and between meal fluids were adequate for Resident #1's hydration. "If he (the resident) chooses to drink, he will meet the goal." The CRD said she knew Resident #1 consumed less food/fluid than was offered and the POA had been repeatedly educated as to risks/benefits of this. The CRD stated staff was taught to honor resident choice to refuse care, including meals and hydration.</p> <p>On interview 12/10/13 at 5:00 p.m. Resident #1's doctor stated Resident #1's dehydration resulted from staff not assisting the resident to eat or drink adequate amounts of food or fluid.</p> <p>RESIDENT #2: Record review found Resident #2 was admitted to the facility [REDACTED]/13 with medically disabling conditions, mild [REDACTED] impairment and history of weight [REDACTED] and [REDACTED] body [REDACTED].</p> <p>Resident #2's admission MDS dated [REDACTED] 13 documented the resident's brief interview for mental status was 14 (cognitively intact). The resident required limited assistance of one person for transfers and toileting.</p> <p>Nutrition evaluation 10/29/13 documented Resident #2's admission weight as [REDACTED] lbs.</p>	F 280		

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F 280	<p>Continued From page 10</p> <p>The evaluation identified Resident #2 was below IBW (less than 19) and a goal would be to reach [REDACTED] pounds or more. The resident was started on nutritionally enhanced meals and meal monitoring.</p> <p>Resident #2's care plan dated 10/31/13 identified cognitive issues and medical issues affected nutrition. Goals of care were to have no unplanned significant weight loss or gain, consume 75% of meals and fluids and tolerate meal texture as ordered. Meal monitoring was to be done. If intake was less than 50%, staff was to offer substitute or supplement. There were no identified parameters as to when to notify the doctor or nutritionist that the resident was not eating adequate amounts of food or fluid.</p> <p>Meal record monitoring from November 1-22 documented Resident #2 refused at least one meal every day and took in less than 1000 cc's/day in fluids. Weight records documented Resident #1 dropped to [REDACTED] lbs 11/9 and [REDACTED] lbs 11/15/13 (7.9 lbs in 2 1/2 weeks). This represents a 5.6% (significant) weight loss in this period of time.</p> <p>On [REDACTED]/13 a nutrition evaluation was conducted and recognized Resident #2 was not eating adequate amounts of food. Nutrition supplements were ordered. The same day, progress notes documented at around 6:30 p.m. Resident #2 was found on the floor in the bathroom, soaked in urine, confused and lethargic. The doctor was present in the building and ordered labs which showed the resident and dehydration and was in acute [REDACTED] failure. Resident #2's Sodium was 156 (normal range 135-145), Creatinine was 8.45 (normal range .7</p>	F 280			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505278	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/31/2013
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NAME OF PROVIDER OR SUPPLIER HEALTH AND REHABILITATION OF NORTH SEATTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 13333 GREENWOOD AVENUE NORTH SEATTLE, WA 98133
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F 280	Continued From page 11 to 1.30). Resident #2 was transported to the hospital at 10:30 p.m. On interview 12/10/13 at 5:12 p.m. Resident #1's doctor stated Resident #2's condition was due to the resident was not eating. On interview 12/12/13 at 10:50 a.m. Staff F stated the dietitian is notified first before the doctor so the diet can be changed if needed.	F 280	F-281 Cited Residents Resident #1 nutritional care plan has been reviewed and revised to reflect their current nutritional status. The nutritional care plans include but are not limited to interventions to help prevent significant weight loss and dehydration. Resident #3 has been assessed by his outpatient clinic and their treatment recommendations have been followed. The resident's past primary care physician has been notified of his lack of treatment orders and no longer see patients at this facility.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, nursing services provided by the facility failed to meet professional standards for 3 of 6 residents (#1, #3, #4) reviewed for care from a census of 77 residents. This resulted in Resident #1's significant weight loss and hospitalization for dehydration twice in 6 months, resulted in Resident #4's hospitalization with sepsis and bladder distention and resulted in Resident #3's pancreatic drain site receiving no nursing monitoring or care or 34 days.	F 281	Other residents The care plans for other residents who have had significant weight loss or have a condition that puts them at risk for significant weight loss have had their care plans reviewed and up dated.	1-21-14

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F 281	<p>Continued From page 12</p> <p>Findings include:</p> <p>Professional nursing standards of practice related to wound care, nutrition, hydration and urinary care are identified in Phipps' Medical-Surgical Nursing: Health and Illness Perspectives, 8th Edition, 2007.</p> <p>RESIDENT #1: According to Phipps' page 1171, nursing nutritional assessment includes comparison of the daily intake with standard recommendations in order to determine if problems exist.</p> <p>Record review found that Resident #1 was initially admitted to the facility [redacted]/12 with medically disabling conditions related to [redacted] injury. Due to his [redacted] injury, Resident #1 was not able to converse or communicate his wishes. Resident #1's power-of-attorney (POA) was his decision maker.</p> <p>Observation 12/12/13 at 12:45 p.m. found Resident #1 lying in bed in his room. A tube feeding machine was infusing. Resident #1 was unresponsive to call or touch. The resident was totally dependent on others for care.</p> <p>Medical records document that on [redacted]/13 Resident #1 was admitted to the hospital with excessively high sodium levels indicating dehydration. A feeding tube was placed in the resident's stomach in order to give the resident adequate free water to avoid dehydration.</p> <p>On 8/26/13 facility records document Resident #1's feeding tube fell out and was left out. Record review found that prior to Resident #1's feeding tube falling out, the resident's total fluid</p>	F 281	<p>Other residents with drainage tubes that require a dressing have been assessed and dressing change orders have been received.</p> <p>Other residents who have their Foley catheters removed have been placed on alert charting to be assessed for urinary retention. Their primary care physician has been notified and asked for an order to preform straight catheterization to measure for possible retention problems.</p> <p>Education/Systems Review The Interdisciplinary Team has been re in serviced on revising the resident's care plans when there are changes in status. Appropriate nursing staff will be in-serviced by 01/21/14 or before their next shift if after 01/21/14 on the need to notify a physician to get an order for a dressing change on any site that a resident has a current dressing on it and the need for alert charting to assess for urinary retention. The in-service includes the need to notify the resident's physician to ask for an order to preform straight catheterization to</p>		

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F 281	<p>Continued From page 13</p> <p>needs were calculated as 2100-2500 cc/day including 1500 cubic centimeters (cc) water every day through the feeding tube. There was no nursing plan of care or trial program set up to ensure Resident #1 was able to ingest adequate calories and liquid to maintain nutrition and hydration without a feeding tube.</p> <p>Meal monitoring and nutritional supplement documentation from August - November 2013 showed Resident #1 was receiving 1200-1600 cc fluid per day, far less than the calculated fluid needed. Nursing staff progress notes for September, October and early November 2013 document no feeding/eating issues.</p> <p>Nutrition, hydration, skin committee notes dated 9/24/13 documented Resident #1 had inadequate oral intake at meals and had lost 43 pounds in 6 months. Nutrition notes documented the weight loss was unavoidable as Resident #1's POA insisted on regular textured foods, despite the resident's inadequate oral intake.</p> <p>Medical records document on [REDACTED]/13 Resident #1 was hospitalized a second time with dehydration (sodium 162, normal range 135-145). A feeding tube was placed again.</p> <p>On interview 12/10/13 at 4:55 p.m. Resident #1's doctor stated "Staff did not call or tell me about (Resident #1's) lack of intake of food and fluid" before the resident was found with a sodium of level 162.</p> <p>On interview on 12/16/13 at 11:10 a.m. Staff C stated Resident #1 was very inconsistent in eating and sometimes would not open his mouth.</p>	F 281	<p>measure for possible retention problems. If the physician fails to give an order to preform straight catheterization to measure for possible retention problems or fails to give an order for a dressing change on any site that a resident has a current dressing on it, the in-service will include notifying the DNS of the refusal for follow up with the medical director.</p> <p>Monitoring The DNS or designee will audit the care plans on admission, quarterly and with change of condition to validate that the care plans are an accurate reflection of the resident's nutritional needs. The DNS or designee will conduct audits of residents who are newly admitted or readmitted with drain tubes to ascertain if the site requires a dressing and if so if an order has been received for a dressing change. The DNS or designee will conduct audits of residents who have their foley catheters removed. The audit will include alert charting for urinary retention and orders to preform</p>	

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F 281	<p>Continued From page 14</p> <p>Staff C said there should have been better communication from the nurse's aids that Resident #1 was not eating well. As noted, the meal monitor showed the resident was not taking adequate calories or fluid.</p> <p>On interview 12/19/13 at 12:45 p.m. the consultant registered dietician (RD) for the facility stated staff was honoring resident choice to refuse care, including meals and hydration (even though Resident #1 could not speak or advocate for himself).</p> <p>RESIDENT #4: According to Phipps' page 993 "The adult bladder should not be permitted to hold more than 300 to 500 ml (milliliters) at any time, since greater amounts lead to overdistention and increased susceptibility to infection."</p> <p>Record review found Resident #4 was admitted to the facility [redacted]/12 with [redacted] and [redacted] disabling conditions.</p> <p>Facility records document Resident #1 had a urinary Foley catheter (hollow tube inserted through the urethra into the bladder to drain urine, held in place by a fluid filled balloon).</p> <p>Progress notes staff documented on 11/26/13 Resident #4 became agitated and pulled out his Foley catheter. The doctor ordered staff to discontinue the catheter and monitor for urinary output and monitor for signs and symptoms of infection.</p> <p>There was no documentation by nursing staff after catheter removal from 11/26/13 to 11/28/13</p>	F 281	<p>straight catheterization to measure for possible retention problems. The results of the audits will be forwarded to the Quality Assurance committee to review for further educational opportunities times 3 months.</p> <p>Responsibility The Director of Nursing will be responsible for the ongoing compliance</p>		

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F 281	<p>Continued From page 15</p> <p>at 11:00 a.m. On [REDACTED]/13 at 11:00 a.m. nursing staff documented Resident #4 appeared ill and had a temperature of 104 degrees. Resident #4 was transported to the hospital.</p> <p>Medical records identified that on admission to the hospital [REDACTED]/13 Resident #4 was septic with urinary tract infection and required admission to the intensive care unit. A urinary catheter was inserted, returning 500 milliliters (ml).</p> <p>On interview 12/16/13 at 2:40 p.m. Administrative Staff (AS) #1 and #2 indicated that the lack of nursing documentation reflected that staff did not notice any problems with Resident #4 prior to his hospitalization. See F315 No Catheter, Prevent Uti, Restore Bladder.</p> <p>RESIDENT #3: According to Phipps' page 8, nurses are responsible for patient management systems that support safety, prevent infection and promote health.</p> <p>Record review found Resident #3 was admitted to the facility [REDACTED]/13 for recovery from [REDACTED] recovery from [REDACTED] infection and [REDACTED] (inflammation of the [REDACTED]).</p> <p>Observation 12/16/13 at 9:15 a.m. found Resident #3 seated on his bed without a shirt. The resident was alert, pleasant and conversant. There was a foam dressing on the resident's left mid back area. On interview Resident #3 stated he had a tube at that site for 3 months. It was taken out last week.</p> <p>Record review found there was no initial order or</p>	F 281		

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F 281	Continued From page 16 direction regarding pancreatic drain site care or dressing change over the drain site on admission [REDACTED]/13. Progress notes documented [REDACTED]/13 (20 days after admission) staff left a voice mail with the general surgery clinic regarding the pancreatic drain tube. The same day ([REDACTED]/13) staff documented that a wound doctor who rounds at the facility said "dressings not be changed, only reinforced. Awaiting call to see what general surgery clinic advises." Record review found no follow up orders or further request for drain care directions and no nursing evaluation of the resident's skin around the pancreatic drain site or dressing change from 11/14/13 to 11/28/13 (14 more days). On interview 12/10/13 at 5:00 p.m. Resident #3's doctor stated on 11/28/13 he was asked by staff to address Resident #3's flank pain. The doctor stated when he took off Resident #3's dressing "it looked like (the dressing) was stuck with dirt and grime on the dressing." The doctor said "The nurse said no one touched it (the dressing) because there was no order, but they didn't request an order." On interview 12/16/13 Staff C (10:30 a.m.) and Staff A (1:30 p.m.) both agreed that nursing staff should have requested clarification of wound care orders which was not done. See F309 Provide Care/services For Highest Well Being.	F 281			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309			

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F 309	<p>Continued From page 17</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide necessary care and services related to care and monitoring of wounds and drains for 1 of 6 residents reviewed for care from a census of 77 residents. This placed the resident at risk for infection and poor wound healing.</p> <p>Findings include:</p> <p>Record review found Resident #3 was admitted to the facility [REDACTED]/13 for recovery from surgery, recovery from [REDACTED] infection and [REDACTED] (inflammation of the [REDACTED]).</p> <p>Observation 12/16/13 at 9:15 a.m. found Resident #3 seated on his bed without a shirt. The resident was alert, pleasant and conversant. There was a foam dressing on the resident's [REDACTED] mid back area. On interview Resident #3 stated he had a tube at that site for 3 months. It was taken out last week.</p> <p>Resident #3's minimum data set (MDS) assessment dated 11/15/13 identified the resident had no cognitive impairment, required set-up assistance with activities of daily living and had surgical wounds.</p>	F 309	<p>F-309</p> <p>Cited Residents Resident #3 has been assessed by a Certified Wound Specialist and the treatment recommendation has been followed. Resident #3 has been assessed by his outpatient clinic and their treatment recommendations have been followed. The resident's past primary care physician has been notified of his lack of treatment orders and no longer see patients at this facility.</p> <p>Other Residents Other residents with drain tubes that require a dressing have been assessed and dressing change orders have been received.</p> <p>Education/System Review Appropriate nursing staff will be in-serviced by 01/21/14 or before their next shift if after 01/21/14 on the need to notify a physician to get an order for a dressing change on any site that a resident has a current dressing on. If the physician fails to</p>	1-21-14

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F 309	<p>Continued From page 18</p> <p>Nursing admission skin assessment identified on admit the resident had a pancreatic drainage tube on the lower back.</p> <p>Initial doctor's orders 10/25/13 included directions for weekly skin assessment head to toe but there was no initial order or direction regarding pancreatic drain site care or dressing change over the drain site.</p> <p>Record review found a telephone order dated 11/14/13 to reinforce the pancreatic drain dressing. There was no direction regarding drain site care.</p> <p>Progress notes document no evaluation of the resident's skin around the pancreatic drain site or dressing change from 10/25/13 to 11/28/13 (34 days). On 11/28/13 orders were received to cleanse the drain insertion site with normal saline, apply calcium alginate and cover with a non-stick dressing twice daily.</p> <p>On 11/28/13 Staff C documented an ulceration was found around the pancreatic tube due to frequent friction with fragile skin. On providing care to the site (per doctor's orders) Staff C documented Resident #3 reported soothing effects of skin treatment for the ulcerated area.</p> <p>On interview 12/10/13 at 5:00 p.m. Resident #3's doctor stated on 11/28/13 he was asked by staff to address Resident #3's flank pain. The doctor stated the dressing looked like it had not been changed "The nurse said no one touched it because there was no order, but they didn't request an order. There was no assessment, they just requested pain medication."</p>	F 309	<p>give an order for a dressing change on any site that a resident has a currently a dressing on it. the in-service will include notifying the DNS of the refusal for follow up with the medical director.</p> <p>Monitoring The Director of Nursing will conduct audits of residents who are newly admitted or readmitted with drain tubes to ascertain if the site requires a dressing and if so if an order has been received for a dressing with dressing change orders. The results of the audits will be forwarded to the Quality Assurance committee to review for further educational opportunities times 3 months.</p> <p>Responsibility The Director of Nursing will be responsible for the ongoing compliance</p>	
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F 309	<p>Continued From page 19</p> <p>On interview 12/16/13 at 10:30 a.m. Staff C stated that orders for dressing change and pancreatic drain care were not written on admission and nursing staff did not pursue getting orders for care. "It was wrong." According to Staff C, both nursing staff and resident care managers have too much to do to follow through at times.</p> <p>On interview 12/16/13 at 1:30 p.m. Staff A (resident care manager) stated communication lines were dropped in this particular case. "I failed to follow up and ensure it (obtaining orders for care) was done. It was a perfect storm of communication and responsibility."</p>	F 309		
F 315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure appropriate monitoring and care after removal of an indwelling urinary catheter for 1 of 3 residents (#4) reviewed for catheter removal from a sample</p>	F 315		

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F 315	<p>Continued From page 20 of 10 residents with indwelling urinary catheters. This may have contributed to the resident's hospitalization with acute sepsis (total body infection) and overdistended bladder.</p> <p>Findings include:</p> <p>Record review found Resident #4 was admitted to the facility [redacted]/12 with medically and cognitively disabling conditions. The resident spoke only a few words of English, as his native language was from another country.</p> <p>Resident #4's minimum data set (MDS) assessment dated 11/21/13 identified Resident #4's brief interview for mental status (BIMS) score was 3, indicating severe cognitive impairment. The resident was able to independently walk around. According to the MDS, Resident #4 had a Foley catheter (hollow tube inserted through the urethra into the bladder to drain urine, held in place by a fluid filled balloon).</p> <p>Resident #4's care plan dated 11/4/13 identified the resident required Foley care every shift. Staff was to assess elimination pattern. There was no other specific information related to how staff should monitor urinary output if the catheter was discontinued.</p> <p>Facility policy identified staff should initiate toileting/retraining assessment protocol as appropriate on removal of a Foley catheter. Alert charting policy identified staff was to chart resident condition every shift for identified areas to monitor.</p> <p>According to medical records, Resident #4 was hospitalized from [redacted]/13 to [redacted]/13. While</p>	F 315	<p>F-315 Cited Residents Resident #4 is no longer at the facility. The resident's past primary care physician has been notified of his lack of orders and no longer sees patients at this facility.</p> <p>Other Residents Other residents who have their Foley catheters removed have been placed on alert charting to be assessed for urinary retention. Their primary care physician has been notified and asked for an order to preform straight catheterization to measure for possible retention problems.</p> <p>Education/System Review Appropriate nursing staff will be in-service by 01/21/14 or before their next shift if after 01/21/14 on the need for alert charting to assess for urinary retention. The in-service will include the need to notify the resident's physician to ask for an order to preform straight catheterization to measure for possible retention problems. If the physician fails to give an order to</p>	1-21-14
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F 315	<p>Continued From page 21</p> <p>hospitalized, a Foley catheter was inserted for urinary retention. The hospital discharge summary documented Resident #4 would likely need the Foley catheter for a week.</p> <p>Progress notes and doctor's orders documented that on 11/7/13 Resident #4's Foley catheter was removed but was reinserted on 11/8/13 when staff noted the resident had an urge to go to the bathroom but there was no urine output.</p> <p>Progress notes staff documented on 11/26/13 Resident #4's Foley catheter was discontinued when the resident became agitated and pulled it out. The doctor ordered staff to discontinue the catheter and monitor for urinary output and monitor for signs and symptoms of infection. The 24 hour report (alert monitoring) directed nursing staff to monitor Resident #4 for urinary retention and signs and symptoms of infection from 11/26/13 to 11/29/13.</p> <p>There was no documentation nursing staff evaluated Resident #4 to determine if normal bladder function had returned on 11/26/13, 11/27/13 or 11/28/13.</p> <p>On 11/28/13 staff documented at 11:00 a.m. the resident was shaking, had a temperature of 104 degrees, and was unable to take oral [REDACTED]. The record documented that family requested the resident be taken to the hospital. Staff called an ambulance for transport.</p> <p>Medical records identified that on admission to the hospital [REDACTED]/13 Resident #4 had unstable blood pressure and pulse and was septic with urinary tract infection. The resident required admission to the intensive care unit for</p>	F 315	<p>perform straight catheterization to measure for possible retention problems the DNS is to be notified of the refusal for follow up with the medical director.</p> <p>Monitoring The Director of Nursing will conduct audits of residents who have their foley catheters removed. The audit will include alert charting for urinary retention and orders to perform straight catheterization to measure for possible retention problems. The results of the audits will be forwarded to the Quality Assurance committee to review for further educational opportunities times 3 months.</p> <p>Responsibility The Director of Nursing will be responsible for the ongoing compliance</p>	

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505278	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/31/2013
NAME OF PROVIDER OR SUPPLIER HEALTH AND REHABILITATION OF NORTH SEATTLE			STREET ADDRESS, CITY, STATE, ZIP CODE 13333 GREENWOOD AVENUE NORTH SEATTLE, WA 98133		
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F 315	<p>Continued From page 22</p> <p>stabilization of his critical condition. A scan performed in the emergency room showed marked distention of the bladder. A urinary catheter was inserted, returning 500 milliliters (ml). Normally a full bladder contains 300-500 ml.</p> <p>On interview 12/10/13 at 9:10 a.m. Resident #4's family member (FM) reported he arrived for a visit on the morning of 11/28/13 and found Resident #4 unable to speak, not moving, and clenching his fists. The FM said no one could answer how long the resident had been that way.</p> <p>On interview 12/16/13 at 2.40 p.m. Administrative Staff (AS) #1 stated that there was no documentation regarding Resident #4's bladder function after removal of the Foley catheter on 11/26/13 because staff only chart by exception. This means that staff only chart if there are problems.</p> <p>On interview 12/16/13 AS #2 stated Resident #4 usually took himself to the bathroom. According to AS #2 staff should and would have monitored the resident's bladder and level of agitation after removal of the Foley catheter. The AS did not know why there was no documentation to support that this was done.</p> <p>On 12/18/13 at 5:08 p.m. the facility faxed late entry progress notes to the department from two staff (G and F) who documented that they did assess Resident #4 and provide care 11/27/13 and 11/28/13 and no urinary or bladder problems were noted.</p>	F 315			

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