

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505417	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2012
NAME OF PROVIDER OR SUPPLIER SAINT ANNE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3540 NORTHEAST 110TH STREET SEATTLE, WA 98125		
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F 000	Continued From page 1	F 000			
F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 157			

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

PRINTED: 04/17/2013
FORM APPROVED
OMB NO. 0938-0391

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F 157	<p>Continued From page 2.</p> <p>by:</p> <p>Based on record review and interviews it was determined the facility failed to notify the physician of delay in the initiation of orders for 2 of 25 current residents (#s 8, 65). This placed the residents at risk for unmet medical needs.</p> <p>Findings include:</p> <p>RESIDENT #8</p> <p>Resident was admitted to the facility in [REDACTED] with [REDACTED]. The resident required extensive assistance for activities of daily living (ADLs).</p> <p>During review of the resident's record on 12/11/12, a doctor's order for [REDACTED]/12 indicated to start treatment for C-diff (an infection of the intestinal tract). The order included 2 medications, [REDACTED] and [REDACTED], which were transcribed to the medication administration record. The [REDACTED] entry had an additional note added by the nurse to start after pharmacy delivers Monday ([REDACTED]/12) resulting in a 3 day delay in treatment.</p> <p>On 12/11/12 at 12:09 p.m., the medication nurse (Staff S) indicated the usual routine for a new order was to send the order to the pharmacy which delivered on Monday, Wednesday, and Friday. If a medication was needed before the next delivery day, Staff S stated "I would call the pharmacy and they would deliver on off days." Staff S said the doctor should be notified if unable to start an order immediately. Staff S reviewed the resident record and verified there was no</p>	F 157	IDR AMENDED	
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F 157	Continued From page 3 notification of the doctor documented.	F 157		
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	<p>At 2:11 p.m., the Director of Nursing (Staff B) stated the pharmacy could be called for a delivery of a medication not in the emergency kit. Staff B was asked if the doctor should be notified when an order is unable to be fulfilled, she did not answer. Staff B reviewed the resident record and verified there was no documentation in the progress notes to address the delay in starting the medication.</p> <p>RESIDENT #65</p> <p>Resident was admitted to the facility in [REDACTED] with [REDACTED]. The resident required minimal assistance for ADLs.</p> <p>On 12/10/12 during review of resident's record, a doctor's order dated 11/13/12, based on psychiatrist recommendation indicated the need for liver function test (LFT) related to the use of an antidepressant. Further review of the record did not reveal the lab was drawn or the doctor was notified of the missed lab order.</p> <p>At 4:00 p.m., the medication nurse (Staff K) indicated the LFT should have been drawn at the facility as it was not one the dialysis center routinely monitored. Staff K stated the lab draws were done on Monday and Thursday so the lab should have been done on 11/15/12. Staff K verified the lab was not drawn and the doctor was not notified of the delay in the lab order.</p> <p>Refer to F309</p>		IDR AMENDED	
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F 157	Continued From page 4	F 157		
F 226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to thoroughly investigate and immediately report alleged incidences of abuse and/or neglect and prevent further similar incidents in accordance with 42 CFR 483.13(c)(3) for 3 of 13 current sampled residents (#s 25, 33, 37) reviewed for mistreatment and abuse. The facility failed to identify, immediately report and investigate allegations of mistreatment or abuse. Facility licensed nursing staff were aware of allegations of mistreatment and possible abuse and failed to recognize that their abuse prevention and protection policy needed to be immediately implemented to protect the residents.</p> <p>Findings include:</p> <p>The facility's abuse policy documented "... Residents must not be subjected to abuse by anyone... It is the policy of this facility that all suspected alleged, or actual cases of resident abuse including injuries of unknown origin, shall be thoroughly and completely investigated and reported according to State and Federal</p>	F 226	<p>IDR AMENDED</p>	

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F 226	Continued From page 5 regulation... It is the responsibility of all staff members to report abuse. It is the responsibility of the Director of Nursing (Staff B) and Administrator (Staff A) of this facility to ensure these policies and procedures are followed..." The facilities procedure for investigations documented, "...As soon as a report of alleged or suspected abuse is received, the investigation shall begin in order to rule out or identify abuse. The investigation will include at a minimum the following steps; Identification of the parties involved. Signs and symptoms or the complaint received that requires investigation, identification of witness. Interviews of all the parties involved, including the resident... Assessment of the involved for injury and need for medical and emotional support." RESIDENT #33 Admitted to the facility on [REDACTED] with diagnoses to include [REDACTED] [REDACTED] The Minimum Data Set (MDS), an assessment tool, indicated the resident was alert and oriented and made decisions regarding her daily care. The resident required extensive assistance with activities of daily living skills to include, transfers, bed mobility and personal hygiene tasks. On 12/7/12 at 1:55 p.m. The resident reported to the surveyor, "Someone took a hold of my arm a couple of days ago and that's how come I have a bruises on my forearm and hands. I don't know the name of the person, I cannot remember. I	F 226	IDR AMENDED		

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F 226	<p>Continued From page 6</p> <p>need help; I don't know what to do ... My hands... sometimes the caregivers are a little rough with me." There was no investigation to rule out abuse or neglect.</p> <p>At 2:00 p.m., The resident's daughter stated, "There was a Nursing Assistant (NA) who my mom had reported was rough with her and she felt that is where the bruising came from."</p> <p>At 2:15 p.m., with the surveyor present, two nurses, Staff P and Staff L talked with The resident about the bruises. The Resident stated, "The bruises are from the NA's being rough with me. When they get me up in the morning, they grab me by the hands and pull me up, that is how I got the bruises."</p> <p>Record review revealed a progress noted dated, 10/31/12, "Resident had a dark red-blue bruise on the back of her left hand and told the LN (Licensed Nurse), 'Someone took hold of my hand and pulled to get me out of bed'."</p> <p>On 12/12/12 at 11:00 a.m., Staff B stated, "Well they should have reported it to me and done an investigation, I don't know what happened, they are trained whenever there is an incident to do an incident report and an assessment, notify the doctor and, family, put them on alert, call the hotline if it is suspicious of abuse. She (the LN) choose to write a progress note. There is no assessment; no monitoring ..., no family was called, no physician notified. We have some training to do."</p> <p>Review of the care plan revealed no updates to reflect new interventions to mitigate the risk of</p>	F 226	IDR AMENDED	
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F 226	<p>Continued From page 7 injury to the resident.</p> <p>RESIDENT #37</p> <p>The resident was admitted to the facility on [REDACTED] with diagnoses to include [REDACTED]</p> <p>The MDS dated 11/6/12 indicated the resident required extensive to total assistance with activities of daily living. The MDS documented mood or behavior issues which interfered with staff's ability to provide care and services to the resident. The MDS documented the resident's vision and hearing was highly impaired.</p> <p>On 12/10/12 at 11:45 a.m., the surveyor with LN Staff S observed two dark purple bruises on the resident's left forearm. Staff S stated, "I did not know of the bruises, this the first time I was made aware of them."</p> <p>Record review revealed multiple bruises documented in the resident's medical record over the past 6 months.</p> <p>On 7/10/12 the Facilities Unusual Occurrence Report (URO) documented, "LN noticed purplish bruise on right hand 4th finger and right hand..."</p> <p>The URO conclusion documented, "Resident tends to yell on occasions while lying in bed. Could be related to Nursing Assistant (NA) taking care of resident or refusing care provided by the NA..." There was no documented investigation to rule out abuse or neglect.</p> <p>There were no interventions added to the care</p>	F 226	IDR AMENDMENT	
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F 226	<p>Continued From page 8</p> <p>plan to mitigate further occurrences of bruises, or approaches in order to address the resident's disruptive/anxious behavior.</p> <p>On 7/27/12 the URO documented, "NA reported bruising to left forearm, discovered on eve 7/27/12."</p> <p>The investigative conclusion did not thoroughly rule out if these bruises were related to abuse and neglect.</p> <p>There were no interventions added to the care plan to mitigate further occurrences of bruises, or approaches in order to address the resident's disruptive/anxious behavior.</p> <p>On 8/17/12 documentation in the resident record documented, "Resident has bruise right arm notified LN." There was no additional documentation or investigation regarding this incident.</p> <p>On 11/6/12 in the nursing progress notes, documentation stated, "Resident has dark blue bruise to back of left hand ..." There was no additional documentation or investigation regarding this incident.</p> <p>On 12/13/12 at 12:20 p.m., the director of nursing (Staff B) stated, "Depending on the occurrence, we would notify the doctor and families, do an assessment, talk to the person....We would update the care plan to decrease the occurrence of the incident, me or possibly the nurse would add interventions to the care plan if needed to be in place right away. To be honest with you the incidents that you have given me there are pages</p>	F 226	<p>IDR AMENDED</p>	
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F 226	<p>Continued From page 9 missing and the care plans have not been updated."</p> <p>At 12:25 p.m., the Social Service Director (Staff C) who was present during the interview with the Staff B offered no insight as to what her role would be in providing medically related social services to ensure resident care needs were met.</p> <p>RESIDENT #25</p> <p>The resident was admitted to the facility on [REDACTED] She was hospitalized [REDACTED] and readmitted to the facility [REDACTED] with diagnoses to include [REDACTED]</p> <p>According to her last completed Minimum Data Set (MDS), an assessment tool, dated 10/4/12 (prior to her hospitalization and readmission), the resident was alert and oriented, and able to make her care needs known. She was independent with wheel chair mobility, transfers, personal hygiene, and limited assistance with toileting. Resident #25 had no behavior concerns which interfered with staff's ability to provide care.</p> <p>On 12/5/11 at 2:00 p.m., during an interview with resident she stated she was concerned with the frequency of her falls. "I stay in bed all the time now."</p> <p>The facility's "Fall Risk Assessment completed 11/19/12 documented a fall risk score of 22 indicating the resident was at "High Risk " for falls.</p>	F 226	<p style="text-align: center;">IDR AMENDED</p>	
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F 226	<p>Continued From page 10</p> <p>Review of the resident record revealed a care plan for falls, dated 11/21/12. Interventions included; Care per MAR (Medication administration Record) and TAR (Treatment Administration Record (TAR) and Pharmacy Consult to evaluate meds.</p> <p>There were no other interventions in the resident's plan of care to mitigate her risk of falls.</p> <p>On 10/1/12 resident #25 sustained a fall in the facility dining room. The UOR documented, "LN was called to dining room at 1900, on arriving pt. (patient) was found sitting on the with her side on against chair and legs under her in standing position." Resident #25 stated, "I tripped on somebody's walker and fell." There were no other interventions in the residents' plan of care to address her risk of falls.</p> <p>On 11/21/12 the resident sustained a fall. The UOR documented, "Resident found lying on left side on floor between bed and window wall. Bed coverings were underneath resident, alert, denied pain. The Summary of the incident documented by the LN "Resident with multi-infarcts needs assist to turn due to right side weakness ...bottom sheet also slid half off the bed with the resident due to slick mattress. There were no interventions added to the residents' plan of care to address or prevent her risk of falls.</p> <p>On 11/30/12 a nursing progress note documented, "Resident was found on floor on left side of bed, on the floor mat ... she was not upset ...Hoyer lift used (mechanical lift) with four person assist to get her back on the bed." No UOR report was completed for this incident, no</p>	F 226	IDR AMENDED		

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F 226	<p>Continued From page 11</p> <p>investigation and no interventions added to the care plan to decrease the likelihood of falls for the resident.</p> <p>On 12/3/12, an UOR documented, "Resident was found lying on her left side on the mat on the floor by the window ...denied hitting her head." There were no interventions added to the residents' plan of care to address her continued falls.</p> <p>On 12/5/23, an UOR documented, "Resident yelled for help and was found by this LN lying halfway out of bed with her legs on the bed and her torso face down on the floor ..."</p> <p>There was no documentation addressing the resident's recent change of condition and/or hospitalization which may have contributed to the falls.</p> <p>On 12/10/12 at 1:45 p.m. and 4:00 p.m., the resident was observed sleeping in a low bed she was observed to be at the very edge of the bed. The resident did not have a call light within reach and no staff were observed to offer the resident toileting assistance. The Resident's room was observed, cluttered, several items in the room make it difficult to traverse easily through.</p> <p>On 12/11/12 at 10:30 a.m. to 12:30 p.m., the resident was observed lying in bed. No staff was observed to offer the resident toileting assistance.</p> <p>At 2:30 p.m., Nursing Assistant (Staff X) stated the resident's condition had declined dramatically in the past two months and she was sleeping a lot during the day.</p>	F 226	<p>IDR AMENDED</p>	
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F 241 SS=D	<p>At 2:30 p.m., Staff B stated several interventions were initiated to prevent the resident's falls. She stated she knew he had a couple of falls since she was readmitted from the hospital. She did not know what interventions had been put in place to mitigate the risk of continued falls for the resident, "We have tried a lot to prevent this resident from falling."</p> <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: Based on observation, interview and record review the facility failed to provide an environment which promoted dignity and respect for 2 of 40 current sampled residents (#s 25,19) during the dining experience. These failures placed the residents at risk for diminished feelings of self-esteem and self-worth.</p> <p>RESIDENT #19</p> <p>Admitted to the facility on [REDACTED] with diagnoses to include dementia. The Minimum Data Set (MDS), an assessment tool dated 11/4/12 documented the resident was independent with eating and required set-up to eat. The resident was unable to make her care needs known.</p> <p>On 12/4/12 at 12:50 p.m., The resident was</p>	F 241			

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F 241	<p>Continued From page 13</p> <p>served her lunch. At 1:00 p.m., the resident continued to receive no cues, or set up assistance with eating. As she picked up food from her plate with her hands she was observed having difficulty bringing food to her mouth as it fell on her clothing protector and lap. She poured a white thick substance over her utensils which sat atop her napkin.</p> <p>Several minutes later, Nurses Aid (NA) Staff W walked by, looked directly at the resident attempting to eat, but, offered no assistance.</p> <p>On 12/5/12 and 12/6/12 at approximately 12:30 p.m., the resident was observed eating with her hands during lunch. No set-up, encouragement or cues were observed offered.</p> <p>Review of the Resident's care plan offered no interventions regarding assistance she required to eat.</p> <p>On 12/11/12 at 6:10 p.m., the resident was observed eating liquid substance in a bowl with her hands. When asked about the residents need for assistance to eat NA Staff T stated, "The aid makes sure to wash the resident's hands after dinner."</p> <p>RESIDENT #25</p> <p>Resident #25 was re-admitted to the facility on [REDACTED] with diagnoses to include dementia. The MDS dated 10/18/12 documented the resident required set-up assistance to eat.</p> <p>On 12/11/12 at 6:30 p.m., NA Staff Z was</p>	F 241			

IDR AMENT

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F 241 Continued From page 14
observed standing up feeding the resident in her room. She stated, she stood by her bedside and assisted the resident to eat. "When you sit down it is not comfortable, when you stand up you can feed more."

F 241

F 250
SS=D 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE

F 250

IDR AMENDED

The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to provide medically related social services for 1 of 3 sampled residents (# 37) reviewed for psychosocial concerns. The facility failed to consistently identify and pursue provision of psycho-social services to meet the needs of residents and to establish an effective way to provide necessary care and services to ensure physical and psychosocial needs were being met. Failure to establish individualized goals and interventions did not ensure their highest practicable level of well-being was attained.

Findings include:

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F 250	Continued From page 15 RESIDENT #37 The resident was admitted to the facility on [REDACTED] with diagnoses to include [REDACTED] The Minimum Data Set (MDS), an assessment tool, dated on 11/6/12 indicated the resident required extensive to total assistance with activities of daily living. The MDS documented mood and behavior issues which interfered with staff's ability to provide care and services to the resident. Her vision was highly impaired, and her hearing moderately impaired. Record review revealed the resident had not had a shower and the facility had not obtained her weight since May 2012. Licensed Nurse (Staff S) stated, "She has been refusing her showers and weights but, she does get a bed bath." Documentation revealed the resident recieved one bed bath in the last 5 months. On 12/4/12 at 1:00 p.m., and 4:00 p.m., the resident was observed in her room, wearing a hospital gown lying in bed sleeping. On 12/6/12 at 8:30 a.m., 10:00 a.m. and 12:00 p.m., 1:00 p.m., 3:00 p.m., and 5:00 p.m. and 12/7/12, intermittently during the day the resident was observed in her room, wearing a hospital gown lying in bed sleeping, flat on her back. On 12/10/12 at 11:37 a.m., the resident was observed in her bed lying flat on her back. Her hair was observed to be tangled, matted, dirty and uncombed. Knots in her tangled hair were	F 250			

IDR AMENDED

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F 250	<p>Continued From page 16 observed around her face.</p> <p>During the survey time frame weekdays 12/4/12 through 12/14/12 p.m., Resident #37 was observed on multiple other occasions lying on her flat on her back in bed calling out, " help, help, help." This behavior continued intermittently throughout the entire day, over several days.</p> <p>On 12/11/12 at 10:50 a.m., the Social Services Director (Staff C) was asked about social service interventions used when a resident was disruptive or resistive to care. Staff C stated, "Well, it is a person by person basis. We try to come up with different approaches and see if certain staff members work better with other residents. We try to see if family can assist." When asked about Resident #37, Staff C stated, "Her family has a difficult time assisting her too." The SSD could not show any documentation of any psychosocial attempts had been made to decrease her resistive or disruptive behavior. There were no interventions or approaches identified in the residents care plan offering different strategies to most effectively work with her. Staff C stated, "I was aware she was not taking showers, but as far as I knew she was taking bed baths, and I was not aware her hair was matted. The nurse or the aides tell me if there are difficult or challenging issues. Yesterday was the first time I was aware of her refusing or her hair being matted. I agree that I should have known."</p> <p>At 11:00 a.m., the consulting psychiatrist stated she had been seeing the resident for medication management over the past year. The psychiatrist was not aware of any behavior issues the resident had experienced regarding refusing care.</p>	F 250	IDR AMENDED	
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F 250	<p>Continued From page 17</p> <p>"I was asked specifically to see her (Resident #37) today regarding resistive behaviors. Mostly I do medication management, verses education for social services or behavior management interventions. We (the mental health agency) are a resource for the facility, we would be able to provide intervention support to assist with effectively dealing with resident behaviors, but, no one has contacted us about this (Resident #37) client.</p> <p>At 11:10 a.m., Staff C confirmed she was aware of the resources a mental health provider. However, there was no documentation a referral had been made.</p> <p>Review of the nursing progress notes, documented several times per week over the past 6 months behavior concerns related to the resident refusing care and yelling at care givers.</p> <p>The last social service note documented in the residents medical record was 2/8/12.</p> <p>There was no documentation found to show social services had been involved in assessing the environmental, medical, and psychiatric causes of problematic behaviors Resident #37 displayed. The facility failed to comprehensively assess Resident #37's behavioral symptoms and implement a plan to include multidisciplinary approaches including non-pharmacological interventions to improve her quality of life at the nursing home, lessen her distress and decrease her disruptive/destructive behavior.</p>	F 250	<p>IDR AMENDED</p>	
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F 250	Continued From page 18	F 250			
F 278 SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to complete, and accurately assess 3 of 25</p>	F 278	IDR AMENDED		

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F 278	<p>Continued From page 19 residents (#s 11, 16, 36) relevant care areas.</p> <p>This failure had the potential to prevent appropriate health professionals from conducting ongoing assessments, to correctly identify and document problems to improve or maintain each resident's medical status, functional abilities, and psychosocial status.</p> <p>Findings include:</p> <p>RESIDENT #16</p> <p>The resident was re-admitted to the facility on [REDACTED] with multiple medical diagnoses to include [REDACTED]</p> <p>Review of the record revealed that the resident had a fall on 8/25/12. A fall risk assessment dated 9/18/12 scored 19, which is a high risk for falls. The Minimum Data Set, an assessment tool (MDS) dated 9/25/12 did not identify that the resident had a fall since the previous assessment date of 7/17/12.</p> <p>On 12/12/12 at 3:23 p.m., the Director of Nursing (Staff B) stated, the MDS coordinator should use the accident and incident book to determine what falls occurred for each time period, and document findings on the MDS. If appropriate, a care plan is created with interventions, and put into place right away. Staff B confirmed that the MDS was inaccurate, and did not document that the resident had a fall.</p> <p>RESIDENT #11</p> <p>The resident admitted in [REDACTED] with multiple</p>	F 278	<p style="text-align: center;">IDR AMENDED</p>	
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F 278	<p>Continued From page 20</p> <p>diagnoses to include diabetes and adult failure to thrive.</p> <p>On 12/05/12 at 11:30 a.m., the resident stated several dental fillings had come out over the past couple of years.</p> <p>Record review of the MDS assessments dated 10/06/12 revealed no acknowledgement of missing fillings.</p> <p>The MDS coordinator stated, she had not been talking with resident's about their dental concerns or examining their mouths.</p> <p>RESIDENT #36</p> <p>Resident was admitted to the facility on [REDACTED] with medically disabling conditions to include [REDACTED]</p> <p>[REDACTED] The resident required one person assist for completion of activities of daily living tasks, transfers and mobility.</p> <p>The MDS completed on 10/8/12 did not address the resident's fall risk or history of falls. Review of the facility accident and injury log revealed the resident experienced a fall in July 2012. The resident record contained a fall risk assessment dated 10/6/12 which identified the resident as a high fall risk with a score of 18 (high risk = 13-27) and this information was not included in the MDS. Since the MDS was inaccurately coded and fall risk not identified interventions were not in place to prevent falls and the resident had a fall on 11/29/12.</p> <p>On 12/7/12 the MDS nurse (Staff D) stated the</p>	F 278	<p>IDR AMENDED</p>	
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F 278	Continued From page 21 information for the MDS comes from the past 7 days charting and the assessments are in a packet for the medication nurse to complete prior to the MDS.	F 278		
F 279 SS=D	<p>On 12/12/12 at 3:11 p.m., Staff B verified the MDS dated 10/8/12 had the resident coded as no fall since the last assessment. Staff B said, "She didn't capture that" and "she should have because she checks this with each MDS (holding up the facility accident and injury log)."</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 279	IDR AMENT	

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F 279

Continued From page 22
Based on observation, interview, and record review it was determined the facility failed to establish care plans for 9 of 25 (12, 19, 25, 26, 31, 36, 37, 46, 49, 57) current sampled residents that accurately reflected measurable objectives and timetables related to the following care needs: accidents, medication administration, grooming, nutrition, positioning, skin conditions, and urinary incontinence. These failures placed residents at risk to receive less than adequate care.

F 279

Findings include:

RESIDENT #46

Resident was admitted to the facility on [REDACTED] with medically disabling conditions to include [REDACTED]. The resident required one person assist for Activities of Daily Living skills (ADL's), transfers and mobility.

The admission Minimum Data Set, an assessment tool, (MDS) dated 6/29/12 coded the resident as always continent, but also recognized the resident was at risk for incontinence. The (Care Area Assessment) CAA identified risks for incontinence and indicated care planning would be initiated.

Review of the resident record revealed no care plan to address the risk of urinary incontinence and related interventions. A care plan was

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F 279	<p>Continued From page 23</p> <p>present for ADL self-care deficit and the need for 1 person assist to toilet. Review of the (Nursing Assistant (NA) care directive printed 11/8/12 found the need for 1 person assist to toilet but did not address the incontinence risk or interventions.</p> <p>On 12/7/12 at 2:09 p.m., the MDS coordinator (Staff D) stated the information for the admission MDS was completed by the past MDS coordinator. Staff D acknowledged she completed the most recent quarterly MDS dated 10/24/12 in which the resident was coded as occasionally incontinent of bladder. Staff D said, "I look at the care plans when I do quarterly and update if needed." Staff D verified there was no care plan in the resident's record to address urinary incontinence.</p> <p><Medications During Meal></p> <p>Observations were made of medication nurse (Staff P) passing medications to residents during meal service.</p> <p>On 12/4/12 at 12:54 p.m, Resident #36 had medications left at the table. Staff P did not observe the medications to be taken.</p> <p>On 12/6/12 at 8:28 a.m., Resident #12 received medication during breakfast.</p> <p>Observations during evening medication pass with medication nurse (Staff N) passing medications during meal service.</p> <p>On 12/10/12., Resident #19 received medications in main dining room and Resident #26 received medications in the restorative dining room.</p>	F 279	<p>IDR AMENDED</p>	

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F 279	Continued From page 24	F 279		
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	<p>On 12/11/12 between the hours of 5:55 p.m. and 6:25 p.m. the Licensed Nurse (Staff K) entered the dining room during the evening meal to give resident's #s 49 and 57 their medications.</p> <p>Review of the records revealed a standing order for resident #s 12, 19, 26, 36, 49 and #57 which documented, okay to give medication during meal time. Further review of the records revealed that the residents did not have individualized care plans addressing their preference to receive medication during dining.</p> <p>RESIDENT #25</p> <p>Resident #25 was admitted to the facility on [REDACTED]. She was hospitalized [REDACTED] and readmitted to the facility [REDACTED] with diagnoses to include [REDACTED].</p> <p>According to her last completed Minimum Data Set (MDS), an assessment tool, dated 10/4/12 (prior to her hospitalization and readmission), the resident was alert and oriented, and able to make her care needs known. She was independent with wheel chair mobility, transfers, personal hygiene, and limited assistance with toileting. Resident #25 had no behavior concerns which interfered with staff's ability to provide care.</p> <p>On 12/5/11 at 2:00 p.m., during an interview with resident she stated she was concerned with the frequency of her falls. "I stay in bed all the time now."</p>		<p>IDR AMENDED</p>	
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F 279

Continued From page 25

F 279

The facility's "Fall Risk Assessment completed 11/19/12 documented a fall risk score of 22 indicating the resident was at "High Risk " for falls.

Review of the resident record revealed a care plan for falls, dated 11/21/12. Interventions included; Care per MAR (Medication administration Record) and TAR (Treatment Administration Record (TAR) and Pharmacy Consult to evaluate meds.

There were no other interventions in the resident's plan of care to mitigate her risk of falls.

RESIDENT #37

The resident was admitted to the facility on [REDACTED] with diagnoses to include [REDACTED]

The Minimum Data Set (MDS), an assessment tool, dated on 11/6/12 indicated the resident required extensive to total assistance with activities of daily living. The MDS documented mood and behavior issues interfered with staff's ability to provide care and services to the resident.

On 12/4/12 at 1:00 p.m., and 4:00 p.m., on 12/6/12 at 8:30 a.m., 10:00 a.m. and 12:00 p.m., 1:00 p.m., 3:00 p.m., and 5:00 p.m., on 12/10/12 at 11:37 a.m., the resident was observed in her room, wearing a hospital gown lying flat in bed sleeping. Her hair was matted and observed to be tangled around her face.

IDR AMENDED

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NAME OF PROVIDER OR SUPPLIER SAINT ANNE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3540 NORTHEAST 110TH STREET SEATTLE, WA 98125
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F 279 Continued From page 26
On 12/10/12 at 11:40 a.m., Licensed Nurse Staff S stated, "Her hair needs brushing and combing." At 11:55 a.m., The Director of Nursing Services (Staff B) stated, "She (Resident #37) has refused showers for a long time... We just encourage her to let us give her a bed bath, the shower aide and the nurses are responsible for that ..."

F 279

F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS
SS=D

F 281

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review it was determined the facility failed to follow the doctor's order related to medication, lab and dressing change orders which resulted in delay of treatment for 2 of 25 sampled residents (#s 8,65)

According to Fundamentals of Nursing, 3rd Edition, (Taylor, Lillis, & LeMone), Fundamentals of Nursing (Lippincott, 3rd Ed.) states, "Nurses are legally responsible for carrying out the orders of the physician in charge of a client."

RESIDENT #8

Resident was admitted to the facility in [REDACTED] with multiple medically disabling conditions to include [REDACTED]

IDR AMENDED

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F 281	<p>Continued From page 27</p> <p>During review of the resident's record on 12/11/12, a doctor's order for [REDACTED]/12 indicated to start treatment for C-diff (an infection of the intestinal tract). The order included 2 medications, [REDACTED] and [REDACTED] which were transcribed to the medication administration record (MAR). The [REDACTED] entry had an additional note added by the nurse to start after pharmacy delivers Monday resulting in a delay of treatment for 3 days.</p> <p>On 12/11/12 at 12:09 p.m., the medication nurse (Staff S) indicated the usual routine for a new order was to send the order to the pharmacy which delivered on Monday, Wednesday, and Friday. If a medication was needed before the next delivery day, Staff S stated "I would call the pharmacy and they would deliver on off days" Staff S said the doctor should be notified if unable to start an order immediately. Staff S reviewed the resident record and verified there was no notification to the doctor documented.</p> <p>At 2:11 p.m., the director of nursing (Staff B) stated the pharmacy could be called for a delivery of a medication not in the emergency kit. Staff B was asked if the doctor should be notified when an order is unable to be fulfilled, she did not answer. Staff B reviewed the resident record and verified there was no documentation in the progress notes to address the delay in starting the medication.</p> <p>RESIDENT #65</p>	F 281	<p>IDR AMENDED</p>	
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F 281 Continued From page 28
Resident was admitted to the facility in [REDACTED] with multiple medically disabling conditions to include [REDACTED]. The resident required minimal assistance for ADLs.

On 12/10/12 during review of resident's record, a doctor's order dated 11/13/12 and based on psychiatrist recommendations indicated the need for liver function test (LFT) related to the use of an antidepressant. Further review of the record did not reveal the lab was drawn or the doctor was notified of the missed lab order.

F 281

IDR AMENDED

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

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

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to ensure appropriate care and services were provided for 1 of 5 current

F 309

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F 309	<p>Continued From page 29</p> <p>sampled residents (#11) in monitoring wheel chair positioning; and 2 of 5 current sampled residents (#8, 65) in implementing doctor's orders. These failures caused the residents to not have the necessary care and services in a timely manner to attain to maintain the highest practicable physical, mental and psychosocial well-being.</p> <p>Findings include:</p> <p>RESIDENT #8</p> <p>Resident was admitted to the facility in [REDACTED] with multiple medically disabling conditions to include [REDACTED]. The resident required extensive assistance for activities of daily living (ADLs).</p> <p>During review of the resident's record on 12/11/12, a doctor's order for [REDACTED]/12 indicated to start treatment for C-diff (an infection of the intestinal tract). The order included two medications, [REDACTED] and [REDACTED] which were transcribed to the medication administration record (MAR). The [REDACTED] entry had an additional note added by the nurse to start after pharmacy delivered 11/12/12 which resulted in a 3 day delay of treatment.</p> <p>On 12/11/12 at 12:09 p.m., the medication nurse (Staff S) indicated the usual routine for a new order was to send the order to the pharmacy which delivered on Monday, Wednesday, and Friday. If a medication was needed before the next delivery day, Staff S stated "I would call the pharmacy and they would deliver on off days." Staff S said the doctor should be notified if unable</p>	F 309	<p>IDR AMENDED</p>	

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F 309	<p>Continued From page 30</p> <p>to start an order immediately. Staff S reviewed the resident record and verified there was no notification of the doctor documented.</p> <p>At 2:11 p.m., the director of nursing (Staff B) stated the pharmacy could be called for a delivery of a medication not in the emergency kit. Staff B was asked if the doctor should be notified when an order is unable to be fulfilled, she did not answer. Staff B reviewed the resident record and verified there was no documentation in the progress notes to address the delay in starting the medication.</p> <p>The delay in initiation of one of the medications ordered for C-diff placed the resident at risk of continued diarrhea, abdominal pain, and dehydration.</p> <p>RESIDENT #65</p> <p>Resident was admitted to the facility in [REDACTED] with multiple medically disabling conditions to include [REDACTED]. The resident required minimal assistance for ADLs.</p> <p>On 12/10/12 during review of resident's record, a doctor's order dated [REDACTED] 12 and based on psychiatrist recommendations indicated the need for liver function test (LFT) related to the use of an antidepressant. Further review of the record did not reveal the lab was drawn or the doctor was notified of the missed lab order.</p> <p>At 4:00 p.m., the medication nurse (Staff K) indicated the LFT should have been drawn at the facility as it was not one the dialysis center</p>	F 309	<p style="text-align: center;">IDR AMENDED</p>	
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F 309	<p>Continued From page 31</p> <p>routinely monitored. Staff K stated the lab draws were done on Monday and Thursday so the lab should have been done on 11/15/12. Staff K verified the lab was not drawn and the doctor was not notified.</p> <p>The omission of the ordered lab placed the resident at risk of untreated abnormal liver function test results. RESIDENT #11</p> <p>The resident admitted to the facility on [REDACTED] with multiple diagnoses including [REDACTED]</p> <p>On 12/05/12 at 11:36 a.m., the resident was observed sitting in a wheel chair that did not accommodate his size. Daily observations during the survey time frame revealed the same wheelchair remained in the resident's room.</p> <p>On 12/10/12 at 11:00 a.m., the Administrator (Staff A) revealed the resident did not have an appropriately fitting wheelchair at admission and the facility provided the resident a temporary wheelchair from their surplus stored in the basement.</p> <p>At 2:00 p.m., the resident stated he had been asking about a new wheelchair to, "Anyone who would listen."</p> <p>Review of care plan revealed the resident had limited mobility and used a bariatric wheelchair, however, no bariatric wheel chair had been obtained for the resident's use. A care conference note dated 10/12/12</p>	F 309	<p style="text-align: center; font-size: 2em; opacity: 0.5;">IDR AMENDED</p>	

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F 309 Continued From page 32 documented by social service director stated, "Resident agreed to use a better fitting wheelchair to be delivered Monday 10/15/12."

On 12/11/12 at 2:20 p.m., the physical therapist (Staff G) stated she was first aware of the problem on 12/03/12. A progress note dated 10/12/12 documented, "A wheelchair 26 inches will be delivered the following Monday per DNS (Director of Nursing)." Staff G asked to investigate this issue and at 2:50 p.m. reported this wheelchair never arrived and the issue was not re-addressed until 12/07/12 when Staff G had a conversation with the resident. Staff G also confirmed the wheelchair in the resident room was 24 inches.

On 12/13/12 at 4:30 p.m., the resident stated he has not gotten out of bed for two days because the wheelchair available was so uncomfortable.

F 309

IDR AMENDED

F 312 SS=D 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS

A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to ensure 1 of 5 current sampled residents (#37) reviewed for personal hygiene received the necessary services to maintain good personal care. Failure to provide

F 312

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F 312	<p>Continued From page 33</p> <p>bathing, grooming and personal care to the resident who was dependent on staff for assistance, placed the resident at risk for skin breakdown, poor personal hygiene, and diminished quality of life.</p> <p>Findings include:</p> <p>The resident was admitted to the facility on [REDACTED] with diagnoses to include [REDACTED]</p> <p>The Minimum Data Set (MDS), an assessment tool, dated on 11/6/12 indicated the resident required extensive to total assistance with activities of daily living skills to include, bathing and personal hygiene tasks. The MDS documented mood and behavior issues interfered with staff's ability to provide care and services to the resident.</p> <p>On 12/4/12 at 1:00 p.m., and 4:00 p.m., On 12/6/12 at 8:30 a.m., 10:00 a.m. and 12:00 p.m., 1:00 p.m., 3:00 p.m., and 5:00 p.m., On 12/10/12 at 11:37 a.m., the resident was observed in her room, wearing a hospital gown lying flat in bed sleeping. Her hair was matted and observed to be tangled around her face.</p> <p>On 12/10/12 at 11:40 a.m., Licensed Nurse Staff S stated, "Her hair needs brushing and combing." Staff S gently lifted up the residents head from the pillow. Her hair was observed to be tangled up so badly no hair could be pulled loose from the knot. Staff S stated, "She refuses care." When asked what interventions were in place to assure care was provided to the resident LN S stated, "The Nursing Assistants (NA's) will continue to offer." Staff S asked the resident if she could</p>	F 312	<p style="text-align: center;">IDR AMENDED</p>	
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F 312	<p>Continued From page 34</p> <p>brush her hair for her. The resident stated, "I don't know where my hair brush is." Observation with Staff S revealed no hair brush or comb in the residents night side stand or room. Staff S stated, "Her (Resident #37) fingernails were jagged, and dirty underneath the nail bed." Brown matter was observed under the index and middle finger of the residents left hand.</p> <p>Record review revealed the resident had not had a shower since May 2012. Staff S stated, "She has been refusing her showers but, she does get a bed bath."</p> <p>Documentation revealed one bed bath or shhwer had been given to the resident on 8/16/12. Staff S stated, "Her family was informed she refused bathing and was getting bed baths."</p> <p>Record review revealed no documentation in the medical record which indicated the family or physician had been notified of the resident's continued refusal of personal care.</p> <p>At 11:55 a.m., The Director of Nursing Services (Staff B) stated, "She (Resident #37) has refused showers for a long time.... I don't know if they give her a bed bath... We just encourage her to let us give her a bed bath, the shower aide and the nurses are responsible for that." Staff B was asked to observe the residents appearance with the surveyor, Staff B stated, "No, I believe what you're telling me."</p> <p>Review of the resident's care plan revealed there was no individualized interventions to address the residents behaviors and/or refusals of care since the initiation of the care plan 2/12/12.</p>	F 312	<p>IDR AMENDED</p>	

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F 312	Continued From page 35	F 312		
	<p>At 4:10 p.m., Staff L stated, "Sometimes they (the nursing assistants) report she is refusing care; it has been a while since they have reported that to me. Upon observation of the resident Staff L stated, " Her hair is dirty, and her scalp dry and scaly, her fingernails are long with brown matter underneath the nail beds." Staff L stated the unkempt condition of the resident was "Not acceptable."</p> <p>On 12/14/12 observations at 11:00 a.m., 1:00 pm and 3:00 p.m., found the residents personal care unchanged from initial observations.</p>		IDR AMENDED	
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 prevent incontinence, improve and restore normal bladder function for 1 of 3 residents (#46) reviewed for urinary incontinence. This failure placed the resident at</p>	F 315		

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F 315	<p>Continued From page 36</p> <p>risk for unmet toileting/incontinence care needs and recurring urinary tract infections (UTI).</p> <p>Resident was admitted to the facility on [REDACTED] with medically disabling conditions to include [REDACTED]. The resident required one person assist for ADLs, transfers and mobility.</p> <p>The admission minimum data set (MDS), an assessment tool, dated 6/29/12 coded the resident as always continent, but did identify the resident had risk factors that could lead to incontinence in the care area assessment tool (CAA). The risk factors included required assistance to toilet, shoulder pain, and history of UTI on admission. The quarterly MDS dated 10/24/12 coded the resident as occasionally incontinent of bladder which indicated a decline in bladder function.</p> <p>Review of the record revealed the resident was not care planned on admission for risk of incontinence and needed interventions to maintain bladder function even though the CAA indicated care planning would address these areas. A care plan for self-care deficit dated 7/5/12 stated the need for toileting assistance was not individualized with risk or interventions. The NAC care directive printed on 11/8/12 also addressed only the need for toileting assistance of one, but did not mention incontinence risks or individualized interventions. The resident record also contained a bladder assessment dated 10/14/12 that identified the resident as continent of bladder, but the nursing progress notes around that timeframe indicated occasional urinary</p>	F 315			

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F 315	Continued From page 37 incontinence.	F 315		
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On 12/7/12 at 2:09 p.m., the MDS nurse (Staff D) stated the resident was incontinent of urine twice in the 7 day look back period for the quarterly MDS so the MDS was coded occasional incontinence. Staff D verified a care plan was not in the resident record to address incontinence risk or interventions needed to maintain bladder function. Staff D said she reviewed the care plans with quarterly MDSs and updated if needed, but she did not do the admission MDS so was not responsible for the care plan not being done originally. When asked if the incontinence would be considered a decline in bladder function, Staff D said "one (care plan) wasn't done with the quarterly MDS since she thought was probably related to C-diff (an intestinal infection) and "if she continues to be incontinent with the next MDS then would be care planned." Staff D verified there was not a toileting program initiated to attempt to regain the bladder function the resident had on admit which was continent of bladder.

Interview with nurse's aid (Staff U) revealed the resident "has occasional incontinence, but mostly uses toilet. She tells us she needs to use the bathroom." Staff U confirmed the resident requires assistance of one person for toileting and personal hygiene.

IDR AMENDED

F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		
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NAME OF PROVIDER OR SUPPLIER SAINT ANNE NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3540 NORTHEAST 110TH STREET SEATTLE, WA 98125		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 38</p> <p>environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to thoroughly investigate, analyze, and implement current interventions and take additional corrective actions to prevent further occurrences of falls for 1 of 3 current sampled residents (#25) reviewed for falls. The facility failed to maintain a safe environment in the shower room, maintenance closet and related to tripping hazards.</p> <p>Findings include:</p> <p>FALLS</p> <p>Resident #25 was admitted to the facility on [REDACTED] She was hospitalized [REDACTED] and readmitted to the facility [REDACTED] with diagnoses to include [REDACTED]</p> <p>According to her last completed Minimum Data Set (MDS), an assessment tool, dated 10/4/12 (prior to her hospitalization and readmission), the resident was alert and oriented, and able to make her care needs known. She was independent with wheel chair mobility, transfers, personal hygiene, and limited assistance with toileting.</p>	F 323	<p>IDR AMENDED</p>	

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F 323	<p>Continued From page 39</p> <p>Resident #25 had no behavior concerns which interfered with staff's ability to provide care.</p> <p>On 12/5/11 at 2:00 p.m., during an interview with resident she stated she was concerned with the frequency of her falls. "I stay in bed all the time now."</p> <p>The facility's "Fall Risk Assessment completed 11/19/12 documented a fall risk score of 22 indicating the resident was at "High Risk " for falls.</p> <p>Review of the resident record revealed a care plan for falls, dated 11/21/12. Interventions included; Care per MAR (Medication administration Record) and TAR (Treatment Administration Record (TAR) and Pharmacy Consult to evaluate meds.</p> <p>There were no other interventions in the resident's plan of care to mitigate her risk of falls.</p> <p>On 10/1/12 resident #25 sustained a fall in the facility dining room. The "Unusual Occurrence Report (UOR)" documented, "LN (licensed nurse) was called to dining room at 1900, on arriving pt. (patient) was found sitting on the with her side on against chair and legs under her in standing position." Resident #25 stated, "I tripped on somebody's walker and fell." There were no other interventions in the residents' plan of care to address her risk of falls.</p> <p>On 11/21/12 resident #25 sustained a fall. The UOR documented, "Resident found lying on left side on floor between bed and window wall. Bed coverings were underneath resident, alert, denied</p>	F 323	<p style="text-align: center;">IDR AMENDED</p>	
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F 323	<p>Continued From page 40</p> <p>pain. The Summary of the incident documented by the LN-"Resident with multi-infarcts needs assist to turn due to right side weakness ...bottom sheet also slid half off the bed with the resident due to slick mattress. There were no interventions added to the residents' plan of care to address or prevent her risk of falls.</p> <p>On 11/30/12 a nursing progress note documented, "Resident was found on floor on left side of bed, on the floor mat ... she was not upset ...Hoyer lift used (mechanical lift) with four person assist to get her back on the bed." No UOR report was completed for this incident, no investigation and no interventions added to the care plan to decrease the likelihood of falls for the resident.</p> <p>On 12/3/12, an UOR documented, "Resident was found lying on her left side on the mat on the floor by the window ...denied hitting her head." There were no interventions added to the residents' plan of care to address her continued falls.</p> <p>On 12/5/23, an UOR documented, "Resident yelled for help and was found by this LN lying halfway out of bed with her legs on the bed and her torso face down on the floor ... "</p> <p>There was no documentation addressing the resident's recent change of condition and/or hospitalization which may have contributed to the falls.</p> <p>On 12/10/12 at 1:45 p.m. and 4:00 p.m., the resident was observed sleeping in a low bed she was observed to be at the very edge of the bed. The resident did not have a call light within</p>	F 323	<p>IDR AMENDED</p>	
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F 323	<p>Continued From page 41</p> <p>reach and no staff were observed to offer the resident toileting assistance. The Resident's room was observed, cluttered, several items in the room make it difficult to traverse easily through.</p> <p>On 12/11/12 at 10:30 a.m. to 12:30 p.m., the resident was observed lying in bed. No staff was observed to offer the resident toileting assistance.</p> <p>At 2:30 p.m., Nursing Assistant (Staff X) stated Resident #25's condition had declined dramatically in the past two months and she was sleeping a lot during the day.</p> <p>At 2:30 p.m., Staff B, the Director of Nursing Service (DNS), stated several interventions were initiated to prevent the resident's falls. She stated she knew he had a couple of falls since she was readmitted from the hospital. She did not know what interventions had been put in place to mitigate the risk of continued falls for the resident, "We have tried a lot to prevent this resident from falling."</p> <p>SHOWER ROOM</p> <p>On 12/4/12 at 11:37 a.m., the shower room on the north hall was accessible as the room door did not lock. The shower room contained several chemicals labeled keep out of reach of children. Inside the shower room was a closet which contained disinfectant cleaner, glass cleaner, tub/tile cleaner, deodorizer, and dandruff shampoo. The closet was unlocked with the key in the lock. On the shower ledge was a gallon of soap and on a shelf next to the shower was deodorant, lotion, Lysol disinfectant pads, and toe nail clippers. Further observations at 1:18 p.m.,</p>	F 323	<p>IDR AMENDED</p>	
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F 323	<p>Continued From page 42</p> <p>and 3:52 p.m., found the room unlocked and the closet unlocked with the chemicals still accessible.</p> <p>On 12/5/12 at 10:05 a.m., the closet door locked and the shower room door remained unlocked with the gallon of soap on shower ledge and other chemicals on the shelf next to the shower.</p> <p>On 12/12/12 at 12:24 p.m., the shower aid (Staff EE) reported the closet, "Should be locked all the time." Staff EE stated, "The key was kept on the side of the closet and another aid must have left it unlocked." Staff EE said she noticed the key in the lock when she came back to work and she locked it right away. When asked about the gallon jugs of soap and other chemicals, Staff EE said, "When I leave for the day I lock everything up."</p> <p>TRIP HAZARD</p> <p>Through all nine days of the survey an electronic box was positioned on the floor outside the door of room #116. Resident #15 explained this box was needed for internet connection for a personal computer. The box had a cord that ran along the floor inside the room and another cord that was plugged into an outlet in the main hallway with a cord unsecured.</p> <p>On 12/14/12 at 10:00 a.m. Administrator, Staff A, stated the electronic box outside of the room #116 occupied by Resident 15 was for internet connection. She did not know if that would be an environmental hazard.</p> <p>MAINTENANCE</p> <p>On 12/11/12 at 3:10 p.m., a key for the</p>	F 323	<p>IDR AMENDED</p>	
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F 323	Continued From page 43 maintenance closet was found in the door knob; the door was unlocked and unsupervised by staff. The closet contained cleaning chemicals. The incident was reported to the DNS who took the key from the door knob and later reported a staff member has opened the door for mopping supplies and had forgotten to lock it.	F 323		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced	F 329	IDR AMENDED	

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F 329	<p>Continued From page 44</p> <p>by:</p> <p>Based on observation, record review and interview it was determined the facility failed to prevent administration of unnecessary medication for 4 of 11 (#s 15, 16, 17, 46) current sampled residents. This placed the residents at risk for clinically significant adverse side effects.</p> <p>Findings include:</p> <p>RESIDENT #15</p> <p>The resident was admitted to the facility on [REDACTED] with diagnoses to include [REDACTED]. The Minimum Data Set, (MDS) an assessment tool, dated 11/08/12 documented resident has a strong cognitive function level (BIMS 15) and mood severity score than indicated the resident had not demonstrated risk for self harm or rejection of plan of care.</p> <p>Record review of Physician orders revealed on [REDACTED]/12 [REDACTED] (a medication used to prevent muscle spasms) was reduced from 8 milligrams (mg) to 6 mg by mouth (po) every 6 hours. Monthly recapitulation orders for December 2012 included nursing to oversee resident's self administration of this medication.</p> <p>On 12/10/12 at 2:15 p.m., the resident showed a half full medication package labeled, "[REDACTED] 8 mg unit doses." Each 8 mg dose in the package consisted of two 4 mg capsules.</p> <p>The resident explained she self medicated with one unit dose every 4 hours to keep her spasms under control. The resident did not want to depend on requesting medication from staff</p>	F 329	<p><i>IDR AMENDED</i></p>	

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F 329	<p>Continued From page 45 because her spasms were unpredictable.</p> <p>On 12/11/12 at 10:30 a.m., the Director of Nursing (Staff B) presented self medication program documentation initiated 4/28/11. The orders on this document confirmed the resident was to self administer [REDACTED] every 6 hours for muscle spasms. The portion of the form for documenting reassessments was blank. A separate sheet entitled "Medication Self-Administration Program Agreement" signed by resident and Staff B on 04/28/11 had a hand written addition, "Take med (medication) on own. LN (Licensed Nurse) to monitor."</p> <p>Review of Medication Administration Record (MAR) on 12/12/12 revealed nurses initial every shift that resident had taken [REDACTED]. There was no further notation detailing how this medication was monitored to include how much or how often. Side effects of the medication included, but were not limited to dry mouth, dizziness, constipation, drowsiness and liver damage.</p> <p>RESIDENT #46</p> <p>Resident admitted to the facility on [REDACTED] with multiple medically disabling conditions to include [REDACTED]</p> <p>Review of the resident's MAR for 11/11/12 revealed two separate entries for a multiple vitamin, Thera-M plus and multiple vitamin with minerals (MVI), initialed as given. On November 11th, the entry for the MVI was stopped and indicated as a duplicate entry.</p> <p>Review of the doctor's orders found the Thera-M</p>	F 329	<p>IDR AMENDED</p>	
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F 329 Continued From page 46
plus was ordered on 6/26/12 and MVI was ordered 10/18/12. The orders were accurately reflected on the October MAR, the resident received only 1 multiple vitamin.

On 12/11/12 at 3:15 p.m., the medication nurse (Staff K) and director of nursing (Staff B) reviewed the November MAR. Staff K acknowledged Thera-M plus was the same as MVI "just a different name." Staff K stated, "Someone noticed and wrote duplicate" and "someone goofed and kept signing it." Staff K and Staff B both agreed an initial in the box indicated the medication was given. Staff B stated, "It looks like she received a vitamin twice daily." Staff K also added, "a copy of the order would be faxed to the pharmacy and they would send it so would be in their drawer."

RESIDENT #16

Resident re-admitted on [REDACTED] with multiple diagnoses to include [REDACTED]

Review of the record revealed a physician's order for [REDACTED] 0.5 mg 1-2 tablets by mouth every one hour as needed for anxiety/agitation. The order did not include a distinction of when to give 1 tablet or when to give 2 tablets in order to use the least amount of medication possible while effectively controlling anxiety/agitation.

On 12/12/12 at 11:49 a.m., Licensed Nurse (Staff S) stated she would start with the lowest dose first, wait an hour and give another. Staff S confirmed that the physician's order did not clearly distinguish when to give 1 tablet and when

F 329

IDR AMENDED

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F 329	Continued From page 47 to give 2 tablets. RESIDENT #17 Resident admitted on [REDACTED] with multiple medical diagnoses to include diabetes, and thyroid disease. On 12/10/12 at 8:19 p.m., LN Staff L was observed to give the resident two Tylenol with codeine tablets for a reported pain level of 7-10. Record review revealed a physician's order for Tylenol 300 mg with codeine 30 mg tablets by mouth 1-2 tablets 5 times a day as needed for pain, not to exceed 4 grams of Tylenol in 24 hours. The order did not include a distinction of when to give 1 tablet or when to give 2 tablets in order to use the least amount of medication possible while effectively controlling pain. At 8:37 p.m., Staff L stated sometimes the resident will tell you when she wants one or two pills depending on her pain level. Staff L confirmed the physician's order did not clearly distinguish when to give 1 tablet and when to give 2 tablets. These failures placed the residents at risk for receiving unnecessary drugs and/or adverse effects from medications.	F 329	IDR AMENDED		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332			

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F 332	<p>Continued From page 48</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it determined the facility failed to ensure staff observed resident consumed all medications and this resulted in a medication administration error rate of 17%. A total of five licensed nurses were observed administering 52 medications to 12 different residents.</p> <p>Findings include:</p> <p>On 12/11/2012 at 11:55 a.m. Licensed Nurse (Staff Q) was observed preparing 9 medication (10 pills) for administration to resident #15. At 12:04 p.m., Staff Q located the resident involved in a facility holiday activity in large open area near the main dining room. Staff Q gave the cup of medications to the resident who put it on the table. Staff Q said nothing to the resident and walked away from the area and did not observe resident taking medications. Upon continued observation of the resident, it was noted the medications were not consumed for an excess of 15 minutes. During this time, the resident left the medications on the table and moved to a different section of the activity.</p> <p>Record review of Saint Anne Corporation Administrative Policy regarding medication administration (page 172) stated, "Make sure to observe the resident taking the medication."</p> <p>On 12/11/12 Interview with the Director of Nursing (Staff B) confirmed licensed staff administering medication are to observe the resident consume</p>	F 332	<p>IDR AMENDED</p>	
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F 332	Continued From page 49 the medication.	F 332		
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F 356 SS=C	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 356	<p>IDR AMENDED</p>	
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F 356 Continued From page 50
Based on observation, interview and record review, it was determined the facility failed to post daily staffing information for 5 of 11 days in December. This failure placed residents and visitors at risk of not being accurately informed of the daily staffing levels.

Findings include:

On 12/4/12 the posting of the daily staffing information was found on a bulletin board across from the nurses' station. The information was for the current day.

On 12/10/12 at 8:00p.m., further review of the posted staffing information revealed postings for 12/1, 12/4-12/7, and 12/10.

On 12/11/12 at 12:19p.m., the administrator reported medical records (Staff J) was in charge of posting staffing hours daily.

At 12:23p.m., Staff C acknowledged she was responsible for posting staffing daily during the week. Staff C stated, "The weekend is done by the nurses or the weekend manager." Staff C verified 5 days were not accounted for in the postings for December and stated, "we missed it for the last 2 weekends."

F 364 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, SS=F PALATABLE/PREFER TEMP

Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.

This REQUIREMENT is not met as evidenced by:

Based on observation and interview, the facility

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F 364	<p>Continued From page 51</p> <p>failed to prepare and serve food that was palatable, at the proper temperatures and that conserved appearance. This placed residents at risk of weight loss and/or not receiving the daily nutritive foods they needed to maintain weight and preserve nutritional parameters.</p> <p>Findings include:</p> <p>During initial rounds in the facility on 12/04/12 and during resident interviews on 12/5/12 and 12/6/12, 13 of 22 residents interviewed complained of food temperatures and/or the quality of food served at the facility.</p> <p>Resident #36 stated the food was not served at the proper temperature, "If I don't get up early enough my breakfast is cold when it gets to my room."</p> <p>Resident #31 stated, "They serve pancakes in the morning every day and they are not good for me." Resident #31 was not aware of any alternatives for breakfast.</p> <p>Resident #16 stated the food did not taste good or look appetizing, "I have a lot of food brought in to me by my daughter and I enjoy going out to eat."</p> <p>Resident #11 stated, "Breakfast is often cold, but I just eat it because I like breakfast food ... The meals on the weekend are not very good. The dinner especially, you can't tell what it is even after you taste it."</p> <p>Resident #25 stated, "...most of the time dinner is cold. They need new food, they bring you</p>	F 364	<p><i>IDR AMENDED</i></p>	
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F 364	Continued From page 52 whatever they want, if you don't like it too bad."	F 364		
	<p>Resident #17 stated, "Foods can be lukewarm."</p> <p>Resident #49 stated, "The food is not good, it is terrible. I spit out a spoonful of the salad I had last week.... A peanut butter and jelly sandwich is the only alternative ...Hot food is cold, lukewarm ..."</p> <p>Resident #40 stated, "The food is not warm enough, I eat in the main dining room."</p> <p>Resident #30 stated, the food did not look or taste good. "I grew up in a nice place so the food is different from what I am used to."</p> <p>Resident #53 stated, "I'm 99 and get ground food." She reported it did not taste good.</p> <p>On 12/11/12 at 4:28 p.m., observations of meal service began. The dietary staff prepared the food and at approximately 4:55 p.m. the tray line service began. The Cook (Staff V) began to prepare the hall trays. The foods and liquids were not observed to have temperatures taken before the service began or during the tray preparation.</p> <p>At 5:00 p.m., Resident #11 stated he did not want the egg salad, no alternate was offered.</p> <p>At 5:10 p.m., Resident #86 stated he did not want the meal that was served, no alternate was offered.</p> <p>At 5:15 p.m., Resident #11 stated, "The food is lousy, there is no choice of menu selection, not</p>		IDR AMENDED	

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F 364	<p>Continued From page 53</p> <p>once I have been here 2 months, no menu, no mention of alternatives. Weekends are the worst, the weekend servers pay no attention to the choices preferences I gave to the dietary manager."</p> <p>Nursing Assistant (Staff Z) stated, the alternative offered for the evening meal was a peanut butter and jelly sandwich or Jell-O. When asked about the main meal alternative Staff Z stated, "No nothing, not usually."</p> <p>Nursing Assistant (Staff X) serving the meals, stated, there were "No alternatives."</p> <p>The evening cook (Staff V) when asked what the alternate meal was for the evening or 12/11/12, stated, "We can make hot dogs."</p> <p>A test tray was done on 12/11/12 during the dinner meal on the hall trays. The temperatures of the food were as follows</p> <p>Egg Salad (served cold) 59 degrees F Pudding (served cold) 63 degrees F Milk (served cold) 55 degrees F Coffee 125 degrees F</p> <p>Review of the temperature log revealed a note which instructed to log temperatures before tray line service began. There were no temperatures in the columns for 12/11/12 dinner. At 5:47 p.m., Staff V verified the log for the dinner meal was not completed and stated, "I didn't write it down but I took the temps."</p> <p>The cold foods were all served on a warm plate next to a bowl of soup. Surveyor review of food,</p>	F 364	<p>IDR AMENDED</p>	
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F 364	Continued From page 54 not attractive, served at the wrong temperature and not palatable. On 12/12/12 at 9:55 a.m., the Dietary Manager (Staff E) stated the policy for monitoring temperatures was "food should be temped and write them (temperatures) down before service. " When asked about alternate meal choices of similar nutritive value, Staff E stated, there was a second menu option available for residents posted on the menu hanging outside of the dining room. Staff E did not know how residents who did not come out of their rooms would know this, or how residents with visual impairments would be able to read the small print on the menu. The alternative meal posted for the evening of 12/11/12 was "tomato soup."	F 364			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to store, prepare, distribute and serve food under sanitary conditions. This placed residents at potential risk	F 371			

IDR AMENDED

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F 371	Continued From page 55 for food borne illness.	F 371		
	<p>Findings include:</p> <p>HAIR RESTRAINTS</p> <p>Throughout the survey process the kitchen staff and facility staff (Staff E, H, Z, AA, BB) was observed to not have hair restraints on to prevent physical contamination of foods.</p> <ul style="list-style-type: none"> - 12/4/12 lunch service - 12/5/12 lunch service and dinner prep - 12/6/12 breakfast service - 12/7/12 breakfast and lunch service - 12/10/12 lunch service and dinner prep - 12/11/12 dinner service - 12/12/12 dinner service <p>On 12/12/12 at 9:55 a.m., the dietary manager (Staff E) stated, "We don't have to wear them (hair nets) anymore, that changed back in the 80s" and then added, "Must have short hair or a covering on hair."</p> <p>FOOD DELIVERY</p> <p>During dinner meal service on 12/11/12, foods were observed to leave the kitchen uncovered. The carts that left the kitchen for the restorative dining room and main dining room did not have covers. The carts contained trays with pudding in small dishes that were not covered.</p> <p>At 5:30 p.m., a nursing assistant (Staff T) was observed to enter the kitchen, fill up 2 cups with hot water and carry the uncovered cups across the hall to the main dining room.</p>		IDR AMENDED	

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F 371 Continued From page 56

F 371

On 12/12/12 at 9:55 a.m., Staff E stated "they cover main plate and liquids, small dishes don't need to be covered."

FOOD STORAGE

On 12/11/12 at 4:30 p.m., inspection of the dry food storage area revealed an opened bag of elbow macaroni and Mexican rice that were not dated when opened.

On 12/12/12 at 9:55 a.m., Staff E stated, "Dry food should be covered, dated and labeled after opened."

IDR AMENDED

F 431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS
SS=D

F 431

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature

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F 431	<p>Continued From page 57</p> <p>controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review it was determined the facility failed to maintain a medication storage area free of expired medications and biologicals; maintain accurate medication records accounting for all controlled medications; and limit access of medications only to authorized staff. These failures created the potential for the residents to receive expired drugs or treatments given with ineffective supplies and unauthorized staff or residents ability to access medications.</p> <p>Findings include:</p> <p>LIMITED ACCESS TO MEDICATIONS:</p> <p>Observation 12/12/12 at 12:25 PM revealed Staff P removed medication keys out of an unlocked desk drawer at the nursing station. At 12:26 P.M. Staff P was asked about this observation and responded, "I put my keys in the drawer by the</p>	F 431	IDR AMENDED	

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F 431	<p>Continued From page 58</p> <p>Staff CC when I go on break. She is sitting there." Staff CC is not authorized to have access to the medication These keys also opened the med cart, med room, and controlled substance cupboard.</p> <p>Observation on 12/7/12 2 10:42 A.M. the medication cart for the north hall was unlocked; This was verified with the Staff M, who responded, "Oops!"</p> <p>Observation on 12/10/12 at 07:20 P.M. revealed the north hall medication cart unlocked. Staff L verified cart was unlocked then locked cart; no further verbal response.</p> <p>MEDICATION STORAGE ROOM:</p> <p>On 12/12/12 at 10:00 A.M. Staff P escorted the surveyor during the inspection of the medication storage area. The refrigerator contained TB test vials opened and undated. Staff P stated, "this should be thrown away." The refrigerator also contained undated food items Staff P stated belonged to the residents; undated, opened thickened water and orange juice; vanilla supplement dated 12/04/2012. Staff P stated this is only kept 48 hours.</p> <p>The locked medication cupboard contained 3 vials of morphine sulfate suspension 2 of which had no open date and the third had open date of 11/06/2012. Staff P stated there is no place to document to account for these bottles. They are normally wasted by 2 licensed nurses as soon as possible.</p> <p>On the counter top, near the sink, laid several</p>	F 431	<p>IDR AMENDED</p>	
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F 431	<p>Continued From page 59</p> <p>medications for Resident #85. Staff P explained these were medications that came with the resident upon admission and are put in a pack and used as needed even though the pharmacy delivers new medications for the resident. When asked if they are normally stored on the counter top, staff P said, "Yes."</p> <p>In the large box specifically used to store Intravenous supplies several bags of IV fluid had expiration date of 7/2012 and 8 expired heparin syringes expired. Staff P stated this kit is stocked by the contracted pharmacy.</p> <p>In the cupboard above the countertop several expired medications were found: 2 boxes of Cymbalta expired 2010; A medication titled, "Restful legs" dated 2008; moisture cream expired 4/2012; Gelnique expired 7/2011.</p> <p>In the 4 drawers and cupboard below the counter top as well as the area under the sink numerous expired items with dates of 2007, 2008, 2009 and 2010. Staff P brought in a box approximately 2 feet X 3 feet X 2 feet deep and filled it with these expired items. Staff P also commented that he does not look in these cupboards or drawers when gathering supplies to care for residents and was unaware of these items. The most outdated items was a nasogastric (NG) placement stylet dated 2002.</p> <p>Staff P proceeded to escort surveyor to supply room downstairs. The items were much more orderly. Staff P stated this is where most often staff will come to for treatment items. Several expired items were also located on these shelves. A box of cups used for medication pass was</p>	F 431	<p style="text-align: center;">IDR AMENDED</p>	
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F 431	Continued From page 60 found on the floor, though most items were stored on palates off the floor. Interview with Staff B 12/13/12 at 9:30 AM when asked who is assigned to clean the medication storage area Staff B stated she cleaned out the medication storage room approximately 2 months ago. She stated she did not go through the cupboards and drawers. She only went through the supplies on top of the counters. Many of the expired items were left by lab services no longer contracted by the facility. Other items she had no explanation for their presence in the medication storage room. Staff B also stated she had no tracking of the Morphine sulfate suspension bottles (3) located in the locked medication cupboard. She explained unused medications are wasted by two nurses as soon as possible. When shown the one container had an open date of 11/6, she had no explanation why it had not been wasted/disposed.	F 431	IDR AMENDED	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441		

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F 441	<p>Continued From page 61</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure that staff disinfected surfaces of washing machines prior to processing cleaned laundry. The facility also failed to ensure that staff delivered clean linen in a way to prevent and control infection transmission. This failure had the potential for the spread of infection from contaminated laundered linens.</p>	F 441	<p>IDR AMENDED</p>	
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F 441	<p>Continued From page 62</p> <p>Findings include:</p> <p>WASHING MACHINE SURFACES:</p> <p>During observation of laundry process on 12-13-12 at 11:14 a.m., laundry supervisor (Staff I), explained laundry procedures for loading washing machines with soiled linen and removal of cleaned linen. (When staff load and unload machines, linen slides over the bottom portion of the washing machine rim by way of possible re-contamination.) Staff I reported washing machine rims surfaces were not disinfected after loading soiled linens into machines or before removing cleaned linens and stated washing machines are cleaned once daily.</p> <p>On 12-13-12 at 11:39 a.m., interview with the Administrator (Staff A) confirmed she was responsible for monitoring and would need to take a look at the process.</p> <p>UNCOVERED LINENS</p> <p>1) 12-7-12 at 2:25 p.m., linen basket outside resident room with folded gowns and blankets, uncovered and unattended, the CNA (Staff T) came out of another resident's room and delivered linen to residents rooms from basket cart</p> <p>2) 12-11-12 at 11:20 a.m., personal laundry delivered uncovered by Housekeeper (Staff GG) and Housekeeping Supervisor (Staff I).</p> <p>3) 12-1-12 at 11:05 a.m., personal laundry delivered uncovered by Staff I and Nurse Aide (Staff Y). When asked about covering laundry for delivery to floor Staff I said, "Never".</p> <p>4) 12-12-12 at approximately 2:00 p.m., the Director of Nursing (Staff B) confirmed that</p>	F 441	<p>IDR AMENDED</p>	
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F 441 Continued From page 63
laundry staff had uncovered linen cart in hallway, and stated that is good information to know.
5) 12-13-12 at 9:28 a.m., Staff I and Housekeeper (Staff FF) delivered uncovered laundry basket.
6) 12-13-12 at 11:42 a.m., Staff FF and Staff I delivered personal laundry uncovered. Staff FF asked if cover is used when laundry is delivered and she said "no".

Linen not delivered to prevent infection, and washing machine surfaces not disinfected before the removal of laundered linen, placed residents at risk for the transmission of infection

F 441

IDR AMENDED

F 456 SS=D 483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION

The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, it was determined that the facility failed to have an operational suction machine in 1 of 2 dining rooms (The Restorative Dining), and failed to have an operational suction machine on the crash cart. This failure placed resident's at risk for not having suction immediately available should an emergency requiring suction occur.

Findings include:

On 12-4-12 at approximately 1:00 p.m. during the

F 456

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F 456	<p>Continued From page 64</p> <p>lunch meal in the Restorative Dining Room, residents were observed to require staff assistance and/or to have altered diets related to swallowing difficulties.</p> <p>On 12-4-12 at 1:05 p.m., an interview with the Licensed Practical Nurse (Staff S) confirmed that the suction machine for the Restorative Dining Room was missing. Staff S reported that the suction machine is usually under the Restorative Dining Room cabinet below the sink, and proceeded to search for the suction machine. Staff S searched in several cabinets in the Restorative Dining Room, and had been unable to locate a suction machine. When unable to locate the suction machine, Staff S reported that the suction machine should be in the clean utility room or in the oxygen room.</p> <p>Observation of the oxygen room on 12-4-12 at 1:12 p.m. with the Restorative Aide (Staff DD) revealed a crash cart covered with a white blanket. Staff DD lifted the blanket stating "the suction machine is usually here, someone must have taken it."</p> <p>On 12-6-12 at 4:36 p.m., an interview with the DNS (Staff B) stated the suction machines are in both dining rooms and on the crash cart.</p> <p>Observation of the crash cart located in the oxygen room on 12-6-12 at 4:47 p.m. with Staff B revealed two bottles of normal saline with expiration dates of 12-09 and 07-12. Staff B reported that the night nurse is responsible to check the crash cart, and was unable to provide documentation that the crash cart had been routinely checked. Staff B provided a check list of</p>	F 456	<p>IDR AMENDED</p>	
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F 456 Continued From page 65 items that were to be on the crash cart. Observation of the crash cart with Staff B revealed several missing items.

Missing Items:

- 1) Suction Machine
- 2) (2) 14 French Suction catheters
- 3) (1) oxygen connecting tubing (25ft)
- 4) (1) CPR mask

Not having operational suction machines in the Restorative Dining Room and on the Crash Cart would cause a delay in staff response to resident(s) should an episode occur that required suctioning.

F 456

IDR AMENDED

F 520
SS=E 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS

A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.

The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

A State or the Secretary may not require disclosure of the records of such committee

F 520

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F 520	<p>Continued From page 66</p> <p>except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review it was determined the facility failed to ensure their Quality Assessment and Assurance (QA &A) committee identified and effectively address issues surrounding abuse and neglect. This failure put all residents at risk for inappropriate care and diminished quality of life.</p> <p>Findings Include:</p> <p>Refer in this report to problems cited under F226, regarding Resident Behavior and Facility Practices 483.12 and the facility 's failure to investigate allegations of mistreatment and possible abuse.</p> <p>Record review of the OSCAR 3 Report revealed this facility has been cited for this issue in three of the last four surveys.</p> <p>On 12/13/12 interview with Staff B, who attends quarterly QA meeting, revealed the QA committee regularly reviewed the trends over the last three months regarding safety along with other issues. Staff B stated serious issues are handled immediately. When asked what does that entail, staff B stated the facility consistently deals with</p>	F 520	IDR AMENDED	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICA SERVICES

PRINTED: 05/17/2013
FORM APPROVED
OMB NO. 0938-0391

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F 520	<p>Continued From page 67</p> <p>things daily to include any further training that needs to happen " with whatever " . Staff B did not mention developing and implementing an appropriate plan of action. Staff B also stated everything is taken to social services. Next meeting review minutes, discuss follow-up and then further issues than have arisen.</p> <p>On 12/13/12 at 2:42P.M. Interview with staff Z revealed direct care staff was unaware of how the QA committee affects their care of the residents.</p> <p>In an interview on 12/13/12 with licensed staff S revealed little understanding of the function of the QA committee. Staff E stated problem are reported to DNS who instructed Staff S how do deal with the problem ... " She has never told me she would take an issue to the QAA committee. "</p> <p>Interview on 12/13/12 at 10:55 A.M. with Staff A who oversee the QA program and coordinates abuse prohibition policies and procedures stated issues was asked to describe how the QA committee has addressed the complaint such as CNA speaking their own language. Staff A initially responded, " If we can catch them doing this; we have a difficult time following up on this complaint. We train and train. " Staff A did not mention how a plan of action is formulated, implemented and evaluated. Staff A also reported problems are addressed at the daily Stand up meetings that happened on the week days. This meeting will discuss issues within a week of it initially being brought to the committee ' s attention. Staff A did not communicate how the Stand Up meeting correlated with the QA meeting. Staff A mentioned repeatedly complaints that are brought to administration by</p>	F 520	<p>IDR AMENDED</p>	
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F 520	Continued From page 68 residents or family are addressed in the QA committee. Staff A was unable to describe how the residents who are nonverbal are regularly survey for problems or complaints. The facility failed to articulate or demonstrate how the QAA committee developed and implemented appropriate plans to address issue that compromised care and quality of life for the residents of this facility.	F 520	IDR AMENDED		