

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

PRINTED: 07/02/2013  
FORM APPROVED  
1324 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505507	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  06/21/2013
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NAME OF PROVIDER OR SUPPLIER  SHELTON HEALTH & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 153 JOHNS COURT SHELTON, WA 98584
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F 000 INITIAL COMMENTS

This report is the result of an unannounced Quality Indicator Survey conducted at Shelton Health and Rehabilitation Center on 6/17/13, 6/18/13, 6/19/13, 6/20/13 and 6/21/13. A sample of 30 residents was selected from a census of 62. The sample included 23 current residents, and the records of 6 former and/or discharged residents.

The survey was conducted by:  
Deborah Barrette, RN, BSN  
[REDACTED], RN,BSN  
[REDACTED], RN, BSN  
[REDACTED], RN, BSN  
[REDACTED], RN, BSN  
[REDACTED], RN,MN

The survey team is from:

Department of Social & Health Services  
Aging & Disability Services Administration  
Residential Care Services, District 3  
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Telephone: (360) 664-8428  
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*[Signature]* 7/12/13  
Residential Care Services Date

F 000

RECEIVED  
JUL 16 2013  
DSHS/ADSA/RCS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>[Signature]</i> SCOTT SPENCER	TITLE EXECUTIVE DIRECTOR	(X6) DATE 7-12-13
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1	F 000		7/26/2013
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 by:</p>	F 157	<p>Res 41 has had his informed consent updated to reflect his current medication use and signed by the POA</p> <p>An audit will be conducted to validate that all informed consents are updated to reflect current medication and signed by the responsible party. Informed consent will be initiated and completed at the time any psychotropic medication is ordered before the medication is administered.</p> <p>Informed consents will be updated with any change in medication and reviewed quarterly to validate accuracy. LN's will be re-educated that informed consent must be obtained by the responsible party before initiating the medication.</p> <p>The RCM's will validate that an informed consent has been obtained at the time the medication is ordered.</p>	

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F 157	<p>Continued From page 2</p> <p>Based on observation, interview and record review, the facility failed to notify the resident's legal representative prior to starting a new medication, and for a change in room or roommate assignment for 1 of 3 (#41) residents reviewed for notification of change in status/treatment/room.</p> <p>Findings include:</p> <p>Resident #41 was admitted to the facility on /13 with diagnoses to include a history of with [REDACTED] and the inability to speak words but did comprehend most language spoken.</p> <p>On 6/5/13, according to the facility documentation, the resident was seen by the medical provider and indicated he had [REDACTED]. The provider prescribed an [REDACTED].</p> <p>On 5/19/13, Resident #41 had been moved to a different room due to a decline in his roommate's condition. There was no evidence the family had been notified of the room change.</p> <p>On 6/18/13, at 12:00 p.m., the family representative stated recently someone from the facility spoke with Resident #41 asking him if he was [REDACTED] and then was placed on an [REDACTED] without notifying the family first. The family member stated Resident #41 was not always aware of what is going on in situations, so the family was concerned that the facility staff were "taking the resident for his word and then the resident doesn't remember saying the things he says."</p>	F 157	<p>The RCM's will review informed consents quarterly to validate that consents are current and accurate. Follow up will be reviewed at the monthly CQI process for the next three months and as needed.</p> <p>The DNS will be responsible for implementing and monitoring this POC.</p>	

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F 157	Continued From page 3  The family member stated the resident had changed rooms since his admission to the facility, and the family was not notified prior; they had come to visit Resident #41 and found he had been moved to another room.  On 6/19/13 at 10:22 a.m., Resident Care Manager (RCM) W stated the facility policy was to notify a resident's family or legal representative prior to starting a new medication. RCM W stated the consent for Resident #41's [REDACTED] was on her desk prior to a planned absence, and not notifying the family regarding the start of the new medication was an oversight.  The Social Services Director (SSD) stated on 6/19/13, the facility process for room moves/roommate changes was to notify the legal representative and each resident prior, but was not done for Resident #41's room change.	F 157			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide toileting assistance in a timely manner for 2 of 42 residents interviewed (#s 42 & 126) to maintain	F 241	Resident 126 no longer resides in facility. Resident 41 is receiving care in an environment that maintains dignity. Managers will conduct routine rounds to identify residents with the potential of being affected by the same practice. Staff will be re-educated on treating residents in a respectful manner that maintains the residents dignity.		

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F 241	<p>Continued From page 4</p> <p>the residents' dignity. This failure placed residents at risk for decreased self-esteem and self-worth not being maintained.</p> <p>Findings include:</p> <p>Resident #126</p> <p>Resident #126 was admitted to the facility on [REDACTED] '13 with diagnoses including [REDACTED] and [REDACTED]. The Minimum Data Set (MDS), an assessment tool dated 6/8/13, documented the resident was "Always continent of bowel and bladder."</p> <p>The resident required extensive assistance of two persons with bed mobility, transfers and toilet use. The resident was alert, oriented and able to communicate her needs.</p> <p>The resident's care plan, dated 5/30/13, documented staff were to assist Resident #126 with activities of daily living that the resident was not able to perform on her own, and to keep Resident #126's normal toileting (to maintain continence).</p> <p>On 6/17/13 at 1:50 p.m., the resident was in bed and neatly groomed. A clock was hanging on the wall at the foot of the resident's bed. The resident stated she had waited 67 minutes and up to one and a half hours for staff to answer her call light. The resident said she had watched the clock after she put on the call light for bathroom assistance. The resident stated it had happened during all shifts and mostly on weekends. The resident said the problems started the third day after the resident was admitted and the latest episodes</p>	F 241	<p>Managers will conduct routine observations that validate that resident dignity is protected. Concerns identified during observations will be corrected and reported during the morning meeting to ensure appropriate action has been taken. Facility staff/designee will conduct random call light audits on all shifts to validate that call-lights are being responded to in a timely manner. Concerns identified will be corrected and reported during the morning meeting to ensure appropriate action is taken to correct any issues. The Executive Director and DNS will review and follow up with all concerns identified and validate that appropriate action has been taken to ensure that residents are receiving care that maintains the residents dignity. Results will be forwarded to CQI committee to review for further educational opportunities. The DNS will be responsible for the ongoing compliance.</p>		

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F 241	<p>Continued From page 5</p> <p>were on 6/15/13 morning and 6/16/13 evening when she waited over 25 minutes for staff to answer the resident's call light. The resident said "I wet the bed because they did not get here fast enough." The resident said she needed assistance with getting to the bed side commode or using the bed pan. The resident stated "I felt like a child again, having to wet the bed. I was humiliated."</p> <p>On 6/20/13 at 7:39 a.m., the resident said another incident happened on 6/17/13 when Nursing Assistant (NA) B assisted the resident onto the bedpan. The resident stated NA B told the resident she had to run down the hall. The resident said she heard NA B tell other staff members that she had put the resident on the bedpan. The resident said she turned her call light after she finished going to the bathroom. The resident said she put on her call light at 7:05 p.m. and staff came in at 7:55 p.m. The resident said "I was mad and angry because it took so long to get help." The resident said " [REDACTED] felt numb and hurt."</p> <p>According to facility documentation, on 6/17/13 the resident was on a bedpan for 45 minutes. The resident had her call light on at 7:05 p.m., and staff did not answer the resident's call light until 7:50 p.m.</p> <p>According to the facility's documentation dated 6/19/13 the resident needed to use the restroom and the resident had her call light on for an hour. The resident call light did not get answered and the resident "urinated in her bed."</p> <p>Resident #42</p>	F 241			

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F 241	<p>Continued From page 6</p> <p>Resident #42 was admitted to the facility on 6/13 with diagnoses including [REDACTED] and [REDACTED]. The resident assessment dated 2/4/13, documented the resident was continent of bowel and bladder. The resident required extensive to total dependence of staff for assistance with mobility and transfers. The MDS assessment dated 5/9/13, documented the resident was "Always continent of bowel and bladder." The resident required extensive assistance of one person for bed mobility, transfer, toilet use and personal hygiene. The resident was alert and oriented and able to make her needs known.</p> <p>The resident care plan dated 2/26/13 documented the resident will be assisted by staff in performing activities of daily living that cannot be met by the resident daily. The resident will achieve and maintain the maximum potential quality of life.</p> <p>On 5/7/13, Social Services (SS) staff documented the resident had often verbalized her call lights not being answered. The resident continued to be alert, oriented and able to make all of her needs known.</p> <p>On 6/17/13 at 2:34 p.m., the resident was in her bed and was neatly groomed. A clock was observed hanging on the wall at the foot of the resident's bed. The resident stated "quite often" she had to wait for an hour for staff to answer her call light. The resident said she had "Waited here. I punched and punched the call bell and no help." Resident #42 stated, "That is not good, especially</p>	F 241		

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F 241	<p>Continued From page 7</p> <p>when I had to go to the bathroom." The resident said "I watched the clock and I waited over an hour." The resident stated, "I just tried to hold it (her urine). I had wet my pants because I waited and waited and waited." The resident said "It has happened a couple of times," and she had "called out for help and then my roommate called for help because I could not get anybody." The resident said "I wet my pants. It doesn't make me feel very good." The resident stated "That is not right that I had to wait over an hour to get to the bathroom and then I wet my pants."</p> <p>On 6/17/13 (Monday) the resident's roommate stated over the weekend evening the resident put on her call bell "Waited and waited until she wet her bed." The resident's roommate said she knew (Named resident) wet herself because the staff came in and had to change the resident's entire bed. The resident's roommate stated she had put on her call light to get help for the resident and "We both waited."</p> <p>On 6/19/13 at 10:55 a.m., Licensed Nurse (LN) N stated not answering the residents call lights would be neglect and not meeting the residents needs in a timely manner was not treating resident with dignity. LN N said answering the residents' call lights was everyone's responsibility.</p> <p>On 6/19/13 at 2:47 p.m., Resident Care Manager (RCM) V said all staff members had been in-serviced and were expected to protect residents from abuse and neglect and treating residents with dignity. RCM V stated all staff members had been in-serviced to answer the residents' call lights and were expected to stop by and acknowledge to the</p>	F 241		

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F 241	<p>Continued From page 8</p> <p>resident that their call light was on. RCM V said if the staff who answered the call light was not able to meet the resident's needs then that staff member was expected to notify the LN for that team. RCM V stated the LN was responsible for ensuring the resident's needs were met. RCM V said she was responsible for ensuring staff answered residents' call lights and their needs were being met in a timely manner. RCM V said she monitored staff answered call lights and treating residents with dignity by observing staff providing care and services.</p> <p>On 6/20/13 at 11:13 a.m. Nursing Assistant (NA) C stated she would answer all residents' call lights and tried to meet the residents' needs as soon as she was able.</p> <p>On 6/21/13 at 11:05 a.m. LN J stated any licensed and/or trained staff was able to assist residents with toileting. LN J said all staff members were responsible for providing the necessary care and services and treat residents with dignity. LN J stated all staff members were responsible for monitoring to ensure the residents was treated with dignity.</p>	F 241		
F 242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p>	F 242	<p>Resident 7 has been interviewed and is receiving care according to her choices. Care plan and Care directives have been updated to reflect the resident's current choices.</p> <p>Managers will conduct routine rounds and interviews to identify</p>	

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F 242	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to consistently honor resident preference for bathing, and/or follow facility policy for assessing bathing preference for 1 of 6 Sampled Residents (#7) reviewed for choices in the Stage 2 review. This failure prevented the resident from exercising her right to make choices regarding her care and had the potential to decrease her quality of life.</p> <p>Findings include:</p> <p>Record review revealed Resident #7 was originally admitted to the facility on [REDACTED] 13 and was readmitted from the hospital on [REDACTED] /13 with diagnoses to include [REDACTED] [REDACTED] of a [REDACTED] and was not able to [REDACTED]. Resident #7 was alert and oriented.</p> <p>The Minimum Data Set (MDS), an assessment tool, dated 5/30/13, documented Resident #7 was totally dependent on facility staff for nearly all activities of daily living. She required extensive assistance of two persons with bed mobility, toileting, bathing and personal hygiene. The MDS further revealed that for Resident #7 it was "very important" to choose between a tub bath, shower, bed bath or sponge bath.</p> <p>Resident #7's Self-care Deficit Care Plan, dated 5/6/13, documented "Receiving Shower" was "Resident Preference."</p>	F 242	<p>residents with the potential of being affected by the same practice. Staff will be re-educated on providing care in accordance with the resident's choice. Managers will conduct routine observations and interviews to validate that the resident's choices are protected. Concerns identified during observations and interviews will be corrected and then reported at the daily morning meeting for appropriate action. RCM's will validate that the residents choices are updated on the plan of care and NAC care directives to ensure care is provided according to resident choice. The DNS will review and follow up with all concerns identified and validate that appropriate action has been taken to ensure the resident choices are included in the care they receive. Results will be forwarded to the CQI committee for three months. The DNS will be responsible for ongoing compliance.</p>

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F 242	<p>Continued From page 10</p> <p>On 6/17/13 at 1:15 p.m., during an interview, Resident #7 stated that facility staff were only providing minimal "spit" baths; she reported she got the "essentials" washed, but not a full bath. She stated her preference would be to have a shower at least once per week but staff were not offering to shower her. She said she assumed this was due to her weak physical condition.</p> <p>On 6/19/13 at 2:55 p.m., during an interview, Resident #7 verified that she would like to be showered at least once per week but staff were not offering her showers. She again stated she assumed this was due to her weak physical condition. When asked how she would respond if staff did offer her a shower, Resident #7 said, "I would say, 'Yes, if you are able to help me.'" During the interview the surveyor observed that Resident #7's hair was matted.</p> <p>On 6/20/13, a review of the shower log for May and June 2013 indicated that, between 5/4/13 and 6/20/13, Resident #7 had a total of 4 showers: 2 with shower aides on 5/13 and 5/29, and 2 with Occupational Therapy on 5/16 and 6/12. The shower log documented that Resident #7 "refused" showers on May 5, 9, 11, 12, 24, 25, 26, 28, and June 4, 6, 8, 11, 16, 17. She was out of the facility from 5/18/13 to 5/23/13.</p> <p>On 6/20/13 at 9:10 a.m., during an interview, Resident Care Manager (RCM) W reviewed the shower log with the surveyor. RCM W stated she was not aware Resident #7 was not being routinely showered and no one told her that Resident #7 was refusing to shower. When asked if the shower log was ever reviewed by licensed staff, RCM W stated that someone was supposed</p>	F 242		

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

PRINTED: 07/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505507	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  06/21/2013
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F 242	<p>Continued From page 11</p> <p>to audit the log periodically and investigate why any resident might be refusing showers; she wasn't sure whose responsibility that was or where their findings might be documented.</p> <p>On 6/20/13 at 9:45 a.m., RCM W stated she just spoke with resident #7 about showers and the resident told her that no one had offered to shower her.</p> <p>On 6/20/13 at 11:20 a.m., during an interview with the Director of Nursing Service (DNS) and Staff B, the DNS stated that the standard method for determining resident preference for shower time and/or frequency was to assign a shower schedule of 2 showers per week and if the resident communicated a preference for a different schedule the facility policy was to attempt to accommodate the resident's preference. Staff did not actively inquire of residents regarding preference for frequency or timing of showers; it was up to residents to independently assert a preference for something other than what was being provided.</p> <p>The DNS stated it was Staff B's responsibility to periodically audit the shower log and investigate residents who were consistently refusing showers. She stated that the facility policy regarding refusal of showers was to try to determine why residents were refusing and offer different time options.</p> <p>Staff B stated she periodically reviewed the shower log but shower aides should report to nursing staff when a resident consistently refused a shower. She stated the policy would be to try different approaches with a resident, including</p>	F 242	

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

PRINTED: 07/03/2013  
FORM APPROVED  
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F 242	Continued From page 12 showers at different times of day or with different shower aides.  Staff B reviewed the shower log and reported that she did not investigate why Resident #7 was refusing showers and stated the facility did not follow its policy with Resident #7.	F 242		
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 oral hygiene was provided for 1 of 42 residents (#42) reviewed for activities of daily living assistance. This failure placed the resident at risk for not receiving the necessary services to maintain good oral health and prevent dental pain.  Findings include:  Resident #42 was admitted to the facility on [REDACTED] 13 with diagnoses including [REDACTED] and [REDACTED]. The Minimum Data Set (MDS) an assessment tool, dated 5/9/13, documented the resident required extensive assistance of one person for her activities of daily living (ADL) and personal	F 312	Resident 42 is being offered oral care by staff TID. Resident 42 has had her care plan and NAC care directives updated to reflect the current level assistance she needs. An assessment of all residents oral care needs will be completed to identify level of assistance required by staff. The care plan and NAC care directive will be updated with the residents current level of care required. Residents will have oral care needs identified on admission and NAC care directives and care plan will be updated to reflect the residents current needs. RCM's will be responsible to validate that NAC care directives and care plans are updated with any changes to ensure that the	

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

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F 312	<p>Continued From page 13</p> <p>hygiene. The resident was alert and oriented and able to make her needs known.</p> <p>The resident care plan, dated 2/26/13, documented the resident was to be assisted by staff in performing ADL's that cannot be met by the resident daily. The resident will achieve and maintain the maximum potential quality of life.</p> <p>On 5/7/13, social service documented the resident continued to be alert, oriented and able to make all of her needs known.</p> <p>During intermittent observation from 6/17/13 11:30 a.m., to 6/19/13 at 2:30 p.m., staff members were not observed brushing the resident's teeth.</p> <p>On 6/19/13 at 2:30 p.m., the resident was in her bed. The resident said "I have my own teeth and they have been sore and dirty because they have not brushing them." The resident stated she needed help brushing her teeth because "of my arthritis hands." The resident stated staff had not brushed the resident's teeth for a few weeks. The resident stated "I should not have to ask them to brush my teeth I don't think." The resident said they had not brush her teeth on 6/19/13 and "It is not very pleasant." The resident said she would like her teeth brushed when she woke up.</p> <p>At 2:30 p.m., Resident #42 was observed to have natural teeth on her upper and lower jaw. The resident's teeth had orange particles attached to her front teeth and white particles deposited on her the upper gum lines.</p> <p>On 6/20/13 at 7:00 a.m., Resident #42 was in her</p>	F 312	<p>residents current needs are identified.</p> <p>Nursing staff will be re-educated on ensuring that residents are receiving the necessary services for ADL's the resident is unable to carry out for themselves.</p> <p>The RCM's will be responsible for auditing that the NAC care directives and care plans are updated with any changes in resident condition to reflect the residents current level of assistance needed. Results will be reviewed at the monthly CQI committee for the next three months.</p> <p>The DNS will be responsible for implementing and monitoring this POC.</p>	

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

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F 312	<p>Continued From page 14</p> <p>bed. The resident said staff had not brushed her teeth.</p> <p>At 7:47 a.m., Nursing Assistant (NA)C delivered the resident's breakfast tray and assisted the resident set up her tray. NA C did not brush the resident's teeth.</p> <p>At 7:56 a.m., NA D responded to the resident's call light. Resident #42 asked NA D for a cup of coffee. NA D left the resident's room and did not brush the resident's teeth.</p> <p>At 8:00 a.m., NA D brought the resident a cup of coffee. NA D left the resident's room and did not brush the resident's teeth.</p> <p>At 8:15 a.m., Staff A removed the breakfast tray for the resident. Staff A did not brush the resident's teeth.</p> <p>At 8:19 a.m., NA D entered resident's room, said "Hi" to the resident and left. NA D did not brush the resident's teeth.</p> <p>At 8:35 a.m., NA D responded to the resident call light. NA D assisted the resident to the bed side commode. NA D did not brush the resident's teeth.</p> <p>At 8:45 a.m., NA D assisted the resident to transfer from the bed side commode to the resident's bed. NA D did not brush the resident's teeth.</p> <p>At 8:50 a.m. Licensed Nurse (LN) O administered oral medications to the resident. LN O did not brush the resident's teeth.</p>	F 312		

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

PRINTED: 07/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

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F 312	<p>Continued From page 15</p> <p>At 9:27 a.m., Restorative Aid entered the resident's room and said "She is sleeping and I don't want to wake her up." The Restorative Aid left the resident's room. The Restorative Aid did not brush the resident's teeth.</p> <p>At 9:38 a.m., the Activity Director (AD) offered the resident books and magazines. The resident declined and the AD left the resident's room. The AD did not brush the resident's teeth.</p> <p>The resident was sleeping from 9:52 a.m., to 11:00 a.m.</p> <p>At 11:04 a.m., the resident said she wanted her teeth brush and staff had not brush her teeth on 6/20/13. Resident #42's teeth had orange particles attached to her front teeth and white particles deposited on her the upper gum lines.</p> <p>At 11:24 a.m., NA D entered the resident's room, looked at the resident and the bed side commode and left. NA D did not brush the resident's teeth. Resident #42 was sleeping.</p> <p>At 11:28 a.m., Restorative Aid assisted the resident out of bed. The resident ambulated in hall.</p> <p>At 11:45 a.m., NA D said the resident's ADL care plan documented the care and services the resident required. NA D said she reviewed the resident's ADL care plan when she was assigned to assist the resident. NA D said the resident required assistance with brushing the resident's teeth. NA D stated she was assigned to assist the resident on 6/20/13 and she did not brush the</p>	F 312		

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

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F 312	Continued From page 16 resident's teeth.  At 11:52 a.m., Resident Care Manager (RCM) V stated the RCMs review the resident assessment information from the inter-disciplinary team and develop an ADL care plan for each resident. RCM V said she would notify the NAs and flagged the ADL care plan for staff to review when there was a change in the resident's ADL care plan. RCM V stated resident's teeth should have been brushed daily in the morning and evening. RCM V said she was responsible for ensuring the residents received assistance with their ADL. RCM V said she observed the residents and staff when she was on the floor to ensure the residents were receiving assistance with their ADL's.	F 312			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to provide comprehensive necessary care and services related to a pressure ulcer for 1 of 3	F 314	Resident 7 has had care plan and NAC care directive updated to reflect the residents current needs. Resident 7 is getting her heels floated off the bed daily per the plan of care. Residents who have been identified with skin problems or potential for skin problems will be audited to validate that interventions are care planned and placed on the NAC care directive.		

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

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F 314	<p>Continued From page 17</p> <p>Sampled Residents (#7) who were reviewed for pressure ulcers in the Stage 2 review. Failure to follow the prescribed pressure ulcer treatment placed the resident at risk for a delay in pressure ulcer healing.</p> <p>Findings include:</p> <p>Resident #7 was admitted to the facility on [REDACTED]/13 and then readmitted from the hospital on [REDACTED]/13, with diagnoses to include [REDACTED] and [REDACTED]. Her admission assessment dated 5/23/13 documented a new Stage One ulcer on her [REDACTED].</p> <p>The Minimum Data Set (MDS), an assessment tool, dated 5/30/13, revealed Resident #7 was non-ambulatory and totally dependent on facility staff for nearly all activities of daily living. She required extensive assistance of two persons with bed mobility, toileting, bathing and personal hygiene.</p> <p>Physician orders for Resident #7, dated 5/23/13, instructed staff to "float" her heels while in bed.</p> <p>The Ulcer Evaluation form, dated 5/23/13, indicated Resident #7 had a Stage One pressure ulcer on her [REDACTED] heel, 3 centimeters (cm) in diameter; the current treatment was to "float heels." The Ulcer Evaluation form, dated 6/18/13, indicated the ulcer remained at Stage One, measured 0.2 cm by 0.5 cm.; the current treatment was "floating heels while in bed."</p> <p>Resident #7's Pressure Ulcer Care Plan, dated 6/14/13, directed staff to "elevate heels off bed</p>	F 314	<p>RCM's will validate that interventions that are care planned are also placed on the NAC care directives to reflect current level of care needed. Care plans and NAC care directives will be reviewed weekly during skin rounds to update any changes.</p> <p>LN's and NAC's will be re-educated on following the residents plan of care and to provide care based on the residents current needs.</p> <p>The DNS will conduct random audits of identified residents and review care plans and NAC care directives to validate that the plan of care reflects the current needs of the resident.</p> <p>RCM's will update the resident plan of care and NAC care directive when a new skin issues is identified. Findings will be reviewed at the monthly CQI meeting for three months and as needed.</p> <p>The DNS will be responsible for implementing and monitoring this POC.</p>	

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

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F 314	<p>Continued From page 18 surface."</p> <p>Resident #7's Care Directive (written resident care instructions for nursing assistants), located in the ADL (Activities of Daily Living) notebook, included no instructions to float or elevate her heels while in bed.</p> <p>On 6/19/13 at 2:47 p.m., during an interview, RCM V stated that the ADL notebook was a primary resource used by licensed nurses in communicating individual resident care directives to nursing assistants.</p> <p>On 6/20/13 at 8:00 a.m., Resident #7 was observed lying in bed on her back. With the resident's permission the surveyor asked Licensed Nurse (LN) J to lift the bedding at the foot of the bed. The resident's heels were observed not elevated and rested directly on the mattress.</p> <p>On 6/20/13 at 8:07 a.m., LN J stated that Resident #7's heels should be elevated off the mattress.</p> <p>On 6/20/13 at 8:37 a.m., Resident Care Manager (RCM) W stated Resident 7's heels should be elevated off the mattress and that she would provide verbal instruction to NA E, the nursing assistant caring for Resident #7 that morning.</p> <p>On 6/20/13 at 9:59 a.m., RCM W stated she spoke with Nursing Assistant (NA) E and that NA E told her she did not know she was supposed to float Resident #7's heels off the bed because she had not seen it on the Care Directive. RCM W and the surveyor reviewed the Care Directive together</p>	F 314		

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

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F 314	Continued From page 19 and RCM W acknowledged that there were no instructions to float or elevate the resident's heels while in bed. RCM W stated she (RCM W) should have written instructions to float the resident's heels on the Care Directive.	F 314		
F 431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>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.</p> <p>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.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</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</p>	F 431	<p>No residents identified</p> <p>All treatment carts have been reviewed and medications have been accurately labeled and separated from each other according to resident medication and house supply medication. LN's will be re-educated on the proper medication storage and labeling of all medications, to include treatments.</p> <p>The SDC will conduct weekly audits on medication and treatment carts to validate that the medications are being stored and labeled according to standards of practice.</p> <p>The SDC will be responsible for auditing med/tx carts and correcting any concerns weekly.</p> <p>Concerns will be brought to the monthly CQI committee for three months and as needed to review</p>	

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

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F 431	<p>Continued From page 20</p> <p>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:</p> <p>Based on observation and interview, the facility failed to store medications in accordance with acceptable standards in 2 of 6 medication storage areas. This failure placed residents at risk for receiving contaminated and/or expired medications, compromising the effectiveness of the medications.</p> <p>Findings include:</p> <p>&lt;Treatment Carts&gt;</p> <p>On 6/20/13, the two facility medication treatment carts were observed. Each cart contained comingled tubes of creams and ointments, some specifically prescribed to residents, others with no label and some with remnants of a prescriptive label, but no resident name or administration directions.</p> <p>Licensed Nurse (LN) J stated the tubes without labels comingled with resident specific tubes were house supply items. LN J stated there was no identification of house supply designation, but just knew they were house supply. LN J stated the tube of enzymatic wound gel with a pharmacy label, but did not have a resident name, drug name or administration directions. LN J stated it</p>	F 431	<p>further educational opportunities.</p> <p>The DNS will be responsible for implementing and monitoring this POC.</p>

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NAME OF PROVIDER OR SUPPLIER  SHELTON HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 153 JOHNS COURT SHELTON, WA 98584		
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F 431	Continued From page 21 was it was being used by some nurses for a current residents although the medication belonged to a resident who had discharged from the facility.  The second medication treatment had the same improper storing, and lack of labels on tubes. Resident specific medications were combined with medications that lacked labels that LN K and RCM V stated were house supply.	F 431		