

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

PRINTED: 05/13/2013
FORM APPROVED
OMB NO. 0938-0391

1328

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505462	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/03/2013
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NAME OF PROVIDER OR SUPPLIER ANDERSON HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 17127 15TH AVENUE NORTHEAST SEATTLE, WA 98155
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(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
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Anderson House Skilled Nursing Facility on 4/25/13, 4/26/13, 4/29/12, 04/30/13, 05/1/13, 5/2/13, and 5/3/13. A sample of 30 residents, including 8 closed records, was selected from a census of 26 residents.</p> <p>Survey team members included:</p> <p>XXXXXXXXXX, MN, RN XXXXXXXXXX, MSW XXXXXXXXXX, MS, RD</p> <p>The survey team is from: Department of Social and Health Services Aging and Long Term Support Administration Residential Care Services, District 2, Unit C 20425 72nd Avenue South, Suite 400 Kent, Washington 98032-2388 Telephone: (253) 234-6000 Fax: (253) 395-5070</p> <p><i>Debra Vora</i> 5-14-2013 Residential Care Services Date</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sheryl Moore RD</i>	TITLE Administrator	(X6) DATE 5-20-13
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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 226
SS=E

483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES

F 226

F226

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to implement policies and procedures that prohibit the neglect and abuse of residents when staff failed to report allegations and/or failed to complete thorough investigations for Residents #47, #16, #3, #18, and #78, five of 9 sample residents for whom incidents of potential abuse/neglect were reviewed. Failure to ensure allegations of abuse were reported and thorough investigations completed did not ensure abuse or neglect was ruled out and placed all residents at risk for harm.

Findings include:

RESIDENT #47:
Resident #47 was admitted in [redacted] 2011 with care needs related to [redacted]. According to his most recent Minimum Data Set (MDS) assessment dated 4/1/13, he had minimal impairment of his [redacted] and was dependent on staff to provide most of his care.

According to an incident investigation, on 1/6/13, Resident #47 told a nurse (Staff Q) he had sustained a bruise on the back of his [redacted]. Staff Q did not document any information about

1. Resident 16 and 78 no longer reside in the facility. Any future reports or allegations of abuse/neglect for residents 3, 18, and 47 will be thoroughly completed and the appropriate notifications will be made. Staff N and R will be retrained on the facility P & P for reporting abuse/neglect and the descriptions of abuse/neglect. Staff B, C, P and Q are no longer employed at the facility.
2. All residents are at risk and will have a thorough investigated completed to rule out abuse/neglect and allegations of or suspected abuse/neglect will be appropriately reported.
3. The facility P & P for investigating and reporting allegations of abuse/neglect was reviewed. Staff N and P will be retrained on the P & P.
4. Administrator or designee will ensure compliance by reviewing all investigations. Findings if any will be reviewed and evaluated as part of the facility on going QAC/QI program.

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Continued From page 2

the resident's bruised hand that shift. Four days later, on 1/10/13, Staff Q documented information about the resident having bruises on both hands. On 1/8/13, another nurse (Staff P) documented the a conversation with Resident #47 about a bruised area on the back of his ~~right~~ hand which measured 10 centimeters (cm) by 11 cm. He told her an unidentified person "came in to do something I didn't want him to, so I knocked him to the floor".

On 1/10/13, Resident #47 told a nursing assistant (Staff R) a "...man came in to his room and grabbed him" when explaining how his right hand was bruised and swollen. He described a similar encounter to another nurse (Staff C) on 1/10/13 and to Staff B on 1/11/13. Despite his allegation that the bruise on his hand was caused by being grabbed by an unidentified male, the facility did not recognize the resident's statements as an allegation of abuse.

None of the staff who documented interactions with Resident #47 contacted the State hotline to report the allegation. Review of the facility's investigation found no documented interviews with staff who provided care for Resident #47 before the bruise was reported/discovered on 1/6/13. On 1/11/13, Staff B (Director of Nursing) concluded "do not believe someone attacked the resident", and he believed the bleeding was due to bumping his hand and use of an ~~anticoagulant~~ medication (_____).

On 5/1/13 at 10:05 am, Staff B was interviewed about the facility's investigation of this incident. He was asked if the resident had blood drawn, was out of bed, or had a shower prior to the

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discovery of the bruises. Staff B replied No to each of these activities. When asked if there were staff on duty who matched the resident's description, he also said there were no staff, volunteers or students who matched the description. When asked which staff were interviewed about their contacts with Resident #47, he said one day shift NA was, but no other staff members were interviewed.

When interviewed about the lack of reporting to the State hotline by himself or other staff, Staff B was asked if Resident #47's statements would be considered an allegation of abuse? He replied "I guess it could be." When Staff B was asked if he had reported this allegation to the State hotline, he replied he had not. When asked why the incident was not reported, he said "Because I didn't think that's what happened". When asked when allegations of abuse were to be reported, he acknowledged they were to be reported immediately to the State hotline. In concluding the interview, the failure by multiple staff (Staff B, C, P, Q and R) to recognize the allegation as one of abuse, or to report it immediately, as required by Federal and State regulations was discussed.

On 5/1/13 at 2:00 p.m., during an interview with Staff B and the facility Administrator (Staff A), she was asked if she reviewed completed investigation for thoroughness. Staff A said she did "look at them and sign them". The elements of the investigation regarding Resident #47's bruised hands and the lack of a thorough investigation were reviewed. While the resident had consistently told of being grabbed by a male staff member, the investigation had not interviewed caregivers who had worked with the

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F 226	<p>Continued From page 4 resident prior to the discovery of the bruise.</p> <p>Failure by facility staff to whom the bruises were initially reported to initiate an investigation did not ensure relevant facts were obtained in a timely way. Failure by subsequent staff to recognize and report the resident's allegation of abuse to the State hotline was also discussed. Failure by staff completing the investigation to document interviews with staff also did not ensure the investigation was thorough. Staff A acknowledged she had not noticed these omissions when she reviewed the investigation.</p> <p>RESIDENT #16: Resident #16 was admitted to the facility on 12/12, with multiple diagnoses including [REDACTED]. The most recent annual assessment indicated the needed extensive assistant from staff for transfers, bed mobility and locomotion in the facility.</p> <p>The care plan noted the resident was at risk for falls and identified interventions in place to minimize the risk of falls and injury including use of a personal alarm to alert staff when the resident was attempting to self transfer. Two of 4 fall investigations reviewed for Resident #16 lacked thoroughness.</p> <p>Fall investigation dated 12/19/13 documented a housekeeper alerted the nursing staff the resident was on the floor. A statement on the investigation noted the resident attempts to self-transfer to use the bathroom, but there was no information about the alarm and or its location or information to identify when the resident was last assisted with the bathroom, the location of the alarm, or what</p>	F 226		

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steps could be taken to prevent additional falls.

Fall investigation dated 3/7/13 documented the resident slipped from his wheelchair while in his room. There was no information about the alarm and why the intervention as care planned was not in place. The investigation log noted that training with staff was completed. The investigation indicated the staff was instructed to assure the seat and cushion were dry. Lack of following the care plan directive for the placement of the alarm was not mentioned.

Not ensuring the care plan interventions were in place at the time of the falls left the facility staff without sufficient information to rule out neglect, and left them without adequate information to assess the effectiveness of current interventions.

RESIDENT #3:
Resident #3 was admitted to the facility on [REDACTED]/13, with multiple diagnoses including [REDACTED] and [REDACTED]. The Initial MDS assessment documented the resident needed extensive assistance with transfers, bed mobility and locomotion.

During review of the clinical record, a progress note entry dated 4/16/13 at 4:29 a.m. noted the resident was found on floor on right side of bed at 3:08 a.m. When asked about the fall incident Staff B reported he was not able to locate an incident report associated with the unwitnessed fall. In addition, the accident/incident reporting log did not identify the fall.

On 5/2/2013 at 2:00 p.m. Staff B reported he was unable to locate an incident report associated

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F 226	<p>Continued From page 6</p> <p>with fall. He indicated the staff that discovered the resident on the floor should have initiated the report to assess the circumstances surrounding the fall but they did not.</p> <p>RESIDENT #18: Resident #18 was admitted to the facility on 4/13 4/13 with multiple medically disabling conditions affecting his mobility and cognition. The initial MDS dated 2/21/13 documented the resident required extensive 2 person assist with bed mobility and toileting. Resident #18's care plan identified the resident was at risk for falls and the resident needed a response to all requests for assistance within a reasonable amount of time.</p> <p>Observation and interview 4/26/13 at 8:30 a.m. found resident #18 seated in bed wearing a hospital gown. The resident did not know how long he had been there, or where he was from and did not know how to call for help. The resident started singing and talking about the casino.</p> <p>Review of an incident report (IR) dated 3/29/13 at 5:07 a.m. documented Resident #18 called for help. The IR documented the resident was found sitting on his bottom, slid having slid off of the air mattress on the bed. The IR documented Resident #18 said "I want to use the urinal and slide out of bed."</p> <p>Facility investigation documented there was an interview with staff who worked at night but did not identify the staff name. The unidentified staff person reported Resident #18 does not call for a urinal and usually does not ask for anything at</p>	F 226		

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night. The IR documented "will monitor" but did not identify what would be monitored. There were no named witnesses or staff on duty. There was no documentation or timeline of when the resident was last toileted or when last seen. There was no evaluation if the care plan was followed.

This information was reviewed with Staff A on 5/2/13 at 5:00 p.m. No additional information to refute the finding of failed practice was provided.

RESIDENT #78:
Resident #78 was admitted to the facility [redacted] 12 with [redacted] resulting in difficulty walking and muscle weakness. The Quarterly MDS dated 4/6/13 identified the resident needed extensive 1 person assistance with bed mobility, transfers, toileting and personal hygiene. Resident #78's care plan identified staff was to assist with care and hygiene including toileting every 4 hours if awake at night.

On interview 4/30/13 at 9:30 a.m. Staff N stated she had just resumed care of Resident #78 the previous day after changing from a previous assignment. Staff N stated Resident #78 told her he just feels treated rudely and does not get help at night. This is told to her by Resident #78 whenever she works with him (today, yesterday, before that a month). Staff N stated that she encouraged the resident to report his concerns to Staff B, but she herself did not report the resident's concerns. Staff N could not say why she did not report.

At 10:00 a.m. on 4/30/13 Staff N reviewed Resident #78's comments with Administrative

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F 226 Continued From page 8
Staff A and B. Staff A told Staff N that Resident #78's comments were allegations of verbal abuse and possible refusal to give care.

Facility abuse reporting policy stated all allegations of abuse will be reported and investigated, with alleged perpetrator suspended pending conclusion of investigation. During the 4/30/13 discussion Staff A stated that abuse training was just done with staff within the last 3 months regarding alerting staff how to respond to and report allegations of abuse.

F 226

F 272 483.20(b)(1) COMPREHENSIVE
SS=D ASSESSMENTS

The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:
Identification and demographic information;
Customary routine;
Cognitive patterns;
Communication;
Vision;
Mood and behavior patterns;
Psychosocial well-being;
Physical functioning and structural problems;
Continence;
Disease diagnosis and health conditions;
Dental and nutritional status;

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Skin conditions;
Activity pursuit;
Medications;
Special treatments and procedures;
Discharge potential;
Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and
Documentation of participation in assessment.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to accurately assess Residents #43, #16, #146, #143, and #35, five of 30 sample residents. Failure to accurately assess weight loss, hydration, skin condition, and pain placed these residents at risk for unidentified and/or unmet needs.

Findings include:

RESIDENT #43:
This resident was admitted on [REDACTED] 13 after a [REDACTED]. Review of her medical record revealed she had multiple [REDACTED]. Review of weights documented by the facility revealed during a 10 day period between 11/8/12 and 11/18/12, she lost 18 pounds, dropping from 180.5 pounds to 162.5 pounds.

F 272

F272

1. Residents 16,35,43, and 143 No longer reside in the facility. Resident 146 has had a modification of the admission assessment.
2. All residents comprehensive assessments will be reviewed for accuracy in order to minimize the risk of unidentified and/or unmet needs
3. Staff responsible for the admission comprehensive assessments was in serviced
4. DNS or designee will ensure compliance by random audit of new admissions. Findings if any will be reviewed and evaluated as part of the facility on going QA/CQI process

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F 272	<p>Continued From page 10</p> <p>Facility records show on [REDACTED] 12 Resident #43 was hospitalized again. When readmitted on [REDACTED] 12, information from the hospital revealed she was admitted for "[REDACTED]" or "[REDACTED]" due to an [REDACTED] and [REDACTED] from [REDACTED]. According to a physician's note dated 11/28/12, Resident #43 also had a history of "[REDACTED]".</p> <p>Review of progress notes after the resident's [REDACTED] 12 admission found multiple entries by nursing staff about her poor nutritional intake, including 12/9/12 "eating poorly, but taking fluids well" and 12/15/12 "Poor appetite, taking fluids well"</p> <p>Review of the 12/6/12 Minimum Data Set (MDS) assessment completed after her [REDACTED] found the facility had not identified or addressed the 18 pound weight loss sustained by Resident #43. Review of the chart since November 1, 2012 found no assessment by the Registered Dietitian regarding her weight loss or other nutritional risk factors/interventions.</p> <p>On 4/30/13 at 1:35 p.m., during an interview with the DNS, Staff B, he was asked to provide any information in Resident #43's record regarding assessment of her nutritional status/ weight loss. After reviewing the chart and computer files, he said "I don't see anything". While this resident was facing the [REDACTED] the issue of potential nutritional needs was not addressed after her [REDACTED] by the facility.</p> <p>RESIDENT #16: Resident #16 was admitted to the facility on [REDACTED] 12 with multiple diagnoses including</p>	F 272		
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F 272	<p>Continued From page 11</p> <p>██████████. The assessment noted the resident needed extensive assistance the transfers, mobility, and toileting. The most recent MDS, dated 4/13 reported no falls had occurred since the last quarterly MDS assessment.</p> <p>On review the facility accident incident reporting log noted Resident #16 experienced four falls between 1/11/13 and 4/13/13, or the quarterly assessment period. The annual assessment of 4/13/13 did not accurately identify the resident's fall history. This may have contributed to unidentified and unmet care needs.</p> <p>RESIDENT #146: Resident #146 was admitted to the facility of ██████/13 with multiple medical diagnoses. The facilities initial nursing assessment, dated 4/21/2013, noted the resident had no skin issues. During the staff interview on 4/26/13 at 10:30 a.m., Staff G reported the resident had pressure ulcers on the ██████ that were present on admission.</p> <p>Review of the clinical record found a physician order for wound treatment was implemented on 4/23/13 and an alternating air pressure mattress was placed on the bed. The physician's note associated with the visit stated the resident had "two dime sized" sacral ulcers. Although the facility policy directed staff to implemented skin monitoring sheets, none were found. The only description of the sacral wounds was found in a progress note, dated 4/23/13. The was no documentation of Resident #146's skin assessment on admission.</p> <p>On interview 4/26/13 at 10:00 am, the resident</p>	F 272		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505462	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/03/2013
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NAME OF PROVIDER OR SUPPLIER ANDERSON HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 17127 15TH AVENUE NORTHEAST SEATTLE, WA 98155
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F 272	<p>Continued From page 12</p> <p>who was alert and oriented reported the sacral ulcers developed in the hospital, prior to admission.</p> <p>Not ensuring the admission assessment accurately identified the resident skin condition may have contributed to the progression of the wounds and a delay in implementing an appropriate treatment plan.</p> <p>RESIDENT #143: Resident #143 was admitted to the facility on [REDACTED] 13 with multiple diagnoses. The initial assessment documented the resident needed extensive assistance from 2 staff with transfers and toileting, and moderate assistance from the staff with other activities of daily living. The assessment indicated the resident had some mild cognitive impairments.</p> <p>Review of the resident's initial nursing assessment, dated 4/18/13, found the resident reported she experienced pain. The resident reported it "Hurts all over" and then stated it is "mostly my legs." She described the pain as severe and stated she experienced pain "all the time." When asked how long the pain lasted she reported until the medication starts working. The resident also reported that pain affected participation in activities, mobility, sleep, mood and the ability to socialize. The initial assessment indicated the resident had a narcotic and over the counter pain medications that were administered as needed.</p> <p>Review of the resident's initial MDS dated 4/25/13 noted the resident assessment did not trigger pain and no additional assessment could be</p>	F 272		
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F 272

Continued From page 13

located in the clinical record. The assessment noted the resident had medications administered as needed and experienced occasional pain and documented details in assessment note resident complained of occasional pain and the assessment indicated the resident pain had no impact on the resident activities of daily living.

Not accurately identifying the resident pain issues contributed to the lack of assessment of the factors contributing to pain and implementing interventions to manage pain. The only mention on the care plan of pain on the care plan was placed under the care plan to prevent pressure sores. This portion of the care plan stated "treat pain as ordered prior to treatment/turning etc. to ensure my comfort." There was no evidence any additional assessment to determine what factors were contributing to pain, this left the facility without adequate information to develop an effective care plan.

RESIDENT #35:
Resident #35 was admitted to the facility on [REDACTED] 13 with multiple diagnosis including [REDACTED] and [REDACTED]. Review initial nursing assessment located in the closed clinical record documented staff observed skin "tenting", which can be a symptom of dehydration.

The initial assessment dated 1/17/13 identified the potential concern and noted that care plan interventions to address the concern would be implemented. Review of the care plan found the only intervention associated with fluid intake was documented under the resident's nutritional support "offer two glasses of fluids each shift in addition to fluids served with meals." The only

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F 272	<p>Continued From page 14</p> <p>other mention of dehydration was noted in the section addressing the potential for skin breakdown. The care plan stated "I have the potential for pressure ulcer development r/t (related to) at risk for dehydration ... "</p> <p>Review of the Care Area Assessment completed in conjunction with the assessment stated the nurses would complete an assessment of the resident hydration status every shift and indicated staff were monitor Intake and Output of fluids to ensure the resident consumed adequate fluid intake. The assessment completed by the Registered Dietician dated 01/23/13, indicated the resident needed to consume 2000 cc's of fluid a day.</p> <p>On 5/3/2013 at 10:00 am, Staff B was asked about the status of the resident fluid intake. He explained that the electronic record created by the nursing assistants required them to document a resident fluid intake every shift. Review of the fluid intake monitor found during the week of 1/19/13 - 1/25/13 the average intake noted by the Nursing Assistants was 1046cc of fluids per day. A calculation of the average intake the last week of the resident stay, as documented by the nursing assistants revealed an daily average intake of 871 cc's of fluid per day.</p> <p>When asked about the documentation of the resident fluid intake Staff B commented "that can't be accurate." He explained the nurses also gave fluids when passing medications but fluids given by the nurses were not documented and not included in the intake monitor.</p> <p>Not ensuring the assessment accurately</p>	F 272		
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F 272	Continued From page 15 assessing the resident's hydration status increased the risk of dehydration.	F 272		
F 279 SS=E	<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: Based on observation, interview, and record review, the facility failed to develop and/or revise comprehensive care plans for Residents #137, #43, #105, #35 and #143, five of 30 sample residents. Failure to establish care plans that accurately reflected assessed care needs related to catheter use, nutrition, discharge planning and</p>	F 279	<p>F279</p> <ol style="list-style-type: none"> The care plan for resident 137 was revised. Residents 35, 43, and 105 no longer reside in the facility. No findings were found for resident 143 in the report. The care plans for all residents will be reviewed for accuracy The process for developing the comprehensive plan of care was reviewed and revised as needed. Staff responsible for the development of the care plan were in serviced DNS or designee will ensure compliance by random audit of all care plans. Findings if any will be reviewed and evaluated as part of the facility on going QA/CQI process 	5-24-13

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F 279	<p>Continued From page 16</p> <p>pain management placed residents at risk for receiving less than adequate care.</p> <p>Findings include:</p> <p>RESIDENT # 137: Resident #137 was admitted on [REDACTED] 13 with care needs related to a recent [REDACTED] and [REDACTED]. On 4/25/13 at 02:20 p.m., during an interview with an RN, Staff G) she stated the catheter was necessary due to urinary retention. Her initial Minimum Data Set (MDS) assessment, dated 3/21/13, did not identify the use of a Foley catheter by this resident.</p> <p>Facility records document on 3/25/13, nursing staff documented Resident #137 had difficulty [REDACTED] and needed to be [REDACTED]. Review of the resident's care plan, dated 3/22/13, found no problem, goals or interventions to address the need for a [REDACTED].</p> <p>On 4/30/13 at 1:57 p.m., during interview with Staff B (Director of Nursing), recent progress notes were reviewed to confirm ongoing use of the [REDACTED] for Resident #47. When asked to review her care plan for goals related to [REDACTED] use, he acknowledged the information was not included in her current care plan. He said it was his expectation that staff revise the care plan when there was a change in the resident's care.</p> <p>RESIDENT #43: This resident was admitted on [REDACTED] 12 with care needs related to multiple [REDACTED] and [REDACTED]. A physician's note dated 11/28/12, identified the resident she had a history of drug resistant [REDACTED] and "severe malnutrition".</p>	F 279		
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F 279	<p>Continued From page 17</p> <p>Review of Resident #43's record found she lost 18 pounds in a ten day period between 11/8/12 and 11/18/12, from 180.5 pounds to 162.5 pounds on 11/18/12, when she was sent to the hospital.</p> <p>Review of her care plan prior to hospitalization and after her admission on 11/20/12, found the facility had not addressed the weight loss or other nutritional risk factors in her care plan. When reviewed, the care plan, dated 10/30/12, did not contain individualized problems, goals or specific interventions to address this resident's weight loss and nutritional needs, except for basic interventions at meals.</p> <p>RESIDENT #105: This resident was admitted on 11/12/12 after hospitalization for a fall with a [redacted] of [redacted]. At the time of her injury, she resided in Assisted Living. Her diagnoses included [redacted] and [redacted].</p> <p>Review of her initial Social Service assessment and her initial Minimum Data Set (MDS) assessment dated 11/11/12 both identified the resident's goal was to return to [redacted]. After a care conference in February 2013, staff documented the resident's discharge plans had changed. She would remain in the nursing care center. Review of the resident's current care plan found no goals or interventions which addressed her discharge planning needs.</p> <p>On 5/3/13 at 10:10 a.m., the Administrator (Staff A) was interviewed about Resident #105's plan to remain in the NH instead of being discharged to</p>	F 279		
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Continued From page 18

Assisted Living. Her current care plan, dated 2/5/13 was reviewed, and the absence of any care plan goals or interventions related to discharge planning since the resident's admission in November 2012 was acknowledged.

RESIDENT #35:
Resident #35 was admitted to the facility on [REDACTED] 13 with multiple diagnosis including [REDACTED] and [REDACTED]. Review of the closed clinical record found the initial nursing assessment dated 1/10/13 documented staff observed skin "tenting", which can be a symptom of dehydration.

The initial assessment identified a care plan to address the risk of dehydration would be written. Review of the care plan found the following statement in the section of the care plan that addressed pressure ulcers. "I have the potential for pressure ulcer development r/t (related to) at risk for dehydration..." The only intervention to address the resident's hydration status stated "offer two glasses of fluids each shift in addition to fluids served with meals."

The care plan did not identify the issue, planned interventions in place, or include a measurable goals or objectives or establish a timetable. Not ensuring the care plan identified and addressed the resident needs hydration needs increased the risk for dehydration.

RESIDENT #143
Resident #143 was admitted to the facility on [REDACTED] 13 with multiple medical diagnosis including a [REDACTED] [REDACTED]. The initial MDS assessment dated 4/25/13 documented the

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F 279	<p>Continued From page 19</p> <p>resident needed extensive assistance with activities of daily living (i.e. transfer, mobility, dressing and hygiene.)</p> <p>The nursing assessment completed on the day of admission 4/18/13 and the initial MDS assessment contained conflicting information concerning the resident pain. The assessment of 4/18, documented the resident complained severe pain all the time, but the MDS assessment documented the resident experienced moderate pain occasionally and that it had no impact on the resident daily activities or sleep.</p> <p>The only directive concerning pain was identified under the potential for pressure ulcers. The directive stated "treat pain per orders prior to treatment /turning etc. to ensure comfort." Review of the residents medication orders found the resident had an orders for two medications that could be administered for pain as needed. One was an analgesic () and the other was a narcotic pain reliever, the orders noted each of the medications could be given every four hours</p> <p>On 4/30/13 at 9:30 am, the resident was greeted while in her room, in bed. She commented she had been up "crying for four hours and unable to sleep" during the nocturnal hours due to pain related to foot cramps. When asked how she would currently rate the pain on the scale from 1 to 10, she reported her pain was a 6. She explained she had taken medications earlier that day, but could not recall if they included pain medication.</p> <p>Review of the April Medication Administration Records found the last dose of a pain medication</p>	F 279	<p>RECEIVED MAY 28 2013 DHS/ADSR/RS</p>	

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F 279	Continued From page 20 the resident had received was administered during the nocturnal hours at 4:35 am. On 4/30/13 new orders for a routine narcotic pain medication were implemented and the first dose was administered at 11:00 am on 4/30/13. Not ensuring care plan directives were developed that identified the issue, provided direction for staff and established goals of a pain management program placed the resident at risk for unmet care needs. On 04/30/13 the resident's representative was present in the facility. When the representative was asked about the pain management regime expressed frustration over the lack of discussion with the provider. He reported the physician had recently made changes with medications without involving him. At 3:00 pm at 4:30 pm, the spouse approached the surveyor and loudly stated Resident #143 was experiencing pain and could not have any medication available to take until later. Staff B overheard the family members comments and verbally reported he would address the concerns expressed by the family concerning lack of pain management. On 5/3/13, during a follow up interview the Resident's Representative stated the issues concerning the resident pain management had been addressed and resolved. Not ensuring a care plan for pain management was developed left the facility staff without sufficient guidance to assist the resident with pain management.	F 279			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281			

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F 281	<p>Continued From page 21</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure nursing services provided met professional standards of quality in order to track skin conditions and prevent and identify soft tissue damage to the penis of 1 of 3 male sample residents (#95) with urinary catheter. This resulted in harm to the resident.</p> <p>Findings include:</p> <p>Phipps' Medical Surgical Nursing Health and Illness Perspectives, 8th edition (Monahan, Sands, Neighbors, Marek, Green) describes skin assessment technique as thorough systematic inspection done in adequate lighting. Lesions are to be described and recorded in terms of shape, size (using metric system), location, color and characteristics "unrecorded data are lost data."</p> <p>Facility policy on skin assessments identified that each resident would have a scheduled weekly head-to-toe skin assessment by a nurse. Staff are to document a - (no skin issue) or + (new or old skin issue) on the Treatment Administration Record (TAR). If a + is noted, staff will initiate a skin assessment in the electronic record. For Pressure Ulcer (PU) is identified on admission, the nurse will measure and document stage, color, drainage, odor, location and size every week until healed and document a + sign on the TAR.</p>	F 281	<p>F281</p> <ol style="list-style-type: none"> 1. Resident 95 will have weekly skin assessments completed with accurate documentation written 2. All residents are at risk for unidentified skin issues 3. LN staff in serviced on the facility P & P for skin assessment and documentation 4. DNS or designee will ensure compliance by random audit of all skin assessments and documentation. Findings if any will be reviewed and evaluated as part of the facility on going QA/CQI process 	5-24-13	

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F 281	<p>Continued From page 22</p> <p>On interview 4/29/13 at 4:15 p.m. Staff A (administrator) stated she trained staff regarding use of the electronic record to document skin monitoring and wound tracking after December 2012.</p> <p>Medical record review found Resident #95 was admitted to the facility [REDACTED] 13. Resident #95's admission minimum data set (MDS - an assessment tool) dated [REDACTED] 12 identified that the resident had a [REDACTED] to drain his [REDACTED]. The MDS identified the resident had one Stage 1 or greater pressure ulcer. (Pressure ulcers are "Staged" from I-IV with Stage I being non-blanchable redness of intact skin and Stage IV being full thickness tissue loss with exposed bone, tendon, or muscle).</p> <p>Initial and weekly skin assessments from 12/2012, 12/25/12 and/or 1/1/13 documented bilateral bruising on arms and legs (not measured or quantified); [REDACTED] pressure ulcer 4.2 x 3.6 cm (centimeter); left elbow swelling 7.2 x 5.8 cm, abdomen bruising 0.8 cm x 1.1 cm. No other documentation of wound, bruise or injury progress was found until March 2013 (2 months later).</p> <p>Treatment Administration Records (TAR) for January, February, March, and April 2013 document monitoring new and old skin conditions (coccyx, buttocks and groin redness, skin tear left elbow, open area left lateral leg) with no ongoing measurement of wounds on skin assessments per facility policy and training.</p> <p>Progress note review found an entry "2/6/13 the</p>	F 281		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505462	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/03/2013
NAME OF PROVIDER OR SUPPLIER ANDERSON HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 17127 15TH AVENUE NORTHEAST SEATTLE, WA 98155		
(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 281	<p>Continued From page 23</p> <p>resident had few drops blood from [redacted] due to pulling on the [redacted]." Weekly skin assessments documented by nurses identified no further [redacted] or related [redacted] problems in February, March or April 2013.</p> <p>Observation 5/2/13 at 1:12 p.m. noted Resident #95's [redacted] looked as if it was coming out the side of the [redacted] or from the [redacted], not from the end of the [redacted]. Investigation found that a 2.3 cm channel had eroded through the skin of the resident's [redacted] due to pressure from the [redacted]. Even with weekly skin checks by nursing staff, no one reported or documented seeing or knowing of this injury until identified by a state surveyor during skin inspection. See findings under Code of Federal Regulations (CFR) 483.25(d)(1)(2).</p> <p>On observation 5/2/13 at 1:31 p.m. Staff I came to Resident #95's bedside and applied [redacted] (prescribed [redacted] cream) to the resident's [redacted]. There was no observed rash or infection. Prescription directions were to apply [redacted] cream to the [redacted] every shift (not the [redacted]) starting 1/28/13. Staff I did not recognize that the resident's skin no longer required application of [redacted] medication. No where in the progress notes or skin assessment was there documentation that the original [redacted] had healed. See findings under CFR 483.25 (m)(1).</p>	F 281			
F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in</p>	F 282			

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F 282	<p>Continued From page 24 accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure care plan interventions for one of four residents (#16) reviewed in Stage II who were at risk for falls. Failure to ensure care plan interventions were consistently implemented left the resident at risk for falls and injury.</p> <p>Findings include:</p> <p>Resident #16 was admitted to the facility on 1/24/12 with multiple diagnoses including Alzheimer's. The most recent Minimum Data Set Assessment, dated 4/13 reported that no falls had occurred. The facility accident injury log indicated the resident had experienced three falls since the last quarterly assessment was completed on 1/11/13.</p> <p>The care plan, dated 1/24/12, identified the resident was at risk for falls and indicated a chair/bed alarm was used to alert staff if the resident attempted to rise from his chair or bed independently. An assessment and consent form, dated 1/7/12, was found in the clinical record. The directives for the staff noted the alarm should be in place at all times. In addition the physician order noted the resident should have an alarm in bed and wheelchair.</p> <p>On 4/29/13 at 12:30 p.m. during the noon meal Resident #16 was in the dining room for lunch</p>	F 282	<p>F 282</p> <ol style="list-style-type: none"> 1. Resident 16 no longer resides in the facility 2. All residents with personal alarms were reviewed to ensure interventions were in place 3. Staff in serviced on following interventions on the care directives 4. DNS or designee will ensure compliance by random audit of all residents using personal alarms. Findings if any will be reviewed and evaluated as part of the facility on going QA/CQI process 	5-24-13
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F 282	<p>Continued From page 25</p> <p>without a personal alarm in place. At 12:58 p.m. the Licensed Nurse, Staff H, attempted to awaken the resident to administer medication, however the resident would not awaken. At 1:07 p.m., the resident was observed leaning forward in his wheelchair while attempting to pick up a paper towel he had dropped on the floor. The resident was observed leaning forward in his wheelchair to the ground in front of the wheelchair. There was no personal alarm in place to alert the staff the resident was leaning forward almost falling out of his wheelchair.</p> <p>The resident remained in his room in his wheelchair without the alarm, intermittently propelling around his room and sleeping until 2:15 p.m., after the surveyor alerted the staff that the resident wanted to lay down, the staff transferred the resident to bed.</p> <p>Review of the incident and accident reporting log for the past six months (October through April) revealed the resident fell in the facility seven times. Four fall investigations were reviewed and two of the investigations, dated 12/19/12 and 3/7/13, did not indicate the care plan to place the alarm was followed. See Code of Federal Regulations (CFR) 483.13(c)(3) for citation associated with lack of thorough investigation.</p> <p>On 5/1/13 at 3:00 p.m., during an interview, Staff G (Resident Care Manager) reported the nursing staff is responsible for ensuring the care plan directives are being followed. When asked about the interventions identified in the care plan, she stated she did not know why the alarm was not in place during the afternoon hours on 4/29/13. She stated the care plans directives should be</p>	F 282			

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F 282	Continued From page 26 followed. The facility failed to ensure assistive devices and supervision was provided to residents as care planned, and increased the risk of resident injury.	F 282	F315	5-24-13
F 315 SS=G	<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 provide the necessary care and services to prevent complications related to a urinary catheter tube in 1 of 3 male residents reviewed for indwelling catheters (#95). The facility failed to recognize, note and intervene to prevent further soft tissue injury until the injury was identified by department staff on 5/2/13 during State survey. This resulted in Resident #95 having his penis flayed open 2.3 cm. causing disfigurement, placing the resident at risk for infection.</p> <p>Findings include:</p>	F 315	<p>1. The erosion caused by the catheter for resident 95 has been assessed and will have weekly assessments completed. Treatment has been revised to minimize further erosion</p> <p>2. The other male residents were assessed for any complications associated with catheter use.</p> <p>3. Staff were inserviced on the complications of indwelling catheters, specifically the possibility of, the identification of and observation for erosion.</p> <p>4. DNS or designee will ensure compliance by random audit of all male residents with indwelling catheters. Findings if any will be reviewed and evaluated as part of the facility on going QA/CQI process</p>	

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F 315

Continued From page 27

Medical record review found Resident #95 was hospitalized 12/16/12 with acute on ~~chronic~~ failure with ~~renal~~ and bladder outlet ~~obstruction~~ and ~~renal~~ (total ~~renal~~) due to ~~chronic~~ dependent ~~diabetes~~ and other medical conditions. The resident was re-admitted to the facility ~~12/16~~/13 with a ~~urinary~~ his ~~bladder~~ and a left ~~ureterostomy~~ tube (tube inserted into the ~~ureter~~ to ~~drain~~ directly from the ~~ureter~~). Facility treatment records showed the ~~ureterostomy~~ tube was discontinued 1/28/13.

Resident #95's admission Minimum Data Set (MDS - an assessment tool) dated ~~12/16~~/12 and quarterly MDS dated 3/19/13 identified that Resident #95 required an indwelling ~~ureterostomy~~ to ~~drain~~ from the ~~ureter~~. An indwelling, or "foley" ~~ureterostomy~~ is a flexible tube inserted through the ~~ureter~~ which remains in the ~~ureter~~. A small inflated balloon at the tip of the ~~ureterostomy~~ keeps in in place. The end of the ~~ureterostomy~~ is connected to a ~~urinary~~. Securing the ~~ureterostomy~~ to the thigh or abdomen decreases the risk of bleeding, trauma, tissue damage, and bladder spasms from pressure and traction on the ~~ureterostomy~~.

Doctor's orders dated 2/20/13 directed foley catheter care every shift, everyday. Resident #95's current care plan directed staff to stabilize the ~~ureterostomy~~ with the leg band (soft velcro strap attached to one leg preventing the ~~ureterostomy~~ from moving around, tugging or pulling) and ~~ureterostomy~~ care every shift. Facility policy defined ~~ureterostomy~~ care as cleansing, securing and positioning the ~~ureterostomy~~ tubing to minimize infection and trauma and maximize drainage of

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F 315	<p>Continued From page 29</p> <p>nurses identified or documented that there was skin erosion or problems related to the residents [redacted] or [redacted].</p> <p>Skin inspection on 5/2/13 1:12 p.m. by department staff was made with Staff I (nurse) and Staff S (Nursing Assistant Certified). The catheter tubing was observed attached to a leg strap on the left thigh. The catheter was not taut, but did not allow slack. The resident's penis appeared intact at the end, and the catheter looked as if it was coming out the side of the penis or from the scrotum, not the end of the penis. Both Staff I and S stated that they had not noticed there was any problem before. Resident #95 did not know there was any problem with his penis or catheter. The resident declined further interview.</p> <p>On interview 5/2/13 at 2:30 p.m. Staff I stated Resident #95's [redacted] tube had been coming out the [redacted] of his penis for a long time. "It has been like that, (I) can't remember. If new it will hurt."</p> <p>On interview 5/2/13 at 4:40 p.m. Staff B (the Director of Nursing) stated that he was not aware of a problem with [redacted] placement or the anatomy of Resident #1's [redacted].</p> <p>On interview 5/3/13 at 8:30 a.m. Staff A (Administrator) said Staff G had done staff training to make sure the [redacted] was secured correctly. Staff A was unsure if any staff noticed any problems with Resident #95's [redacted] or [redacted]. According to Staff A, when she looked on 5/2/13 after notification of the [redacted] condition by department staff, there appeared to be a channel</p>	F 315			

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F 315 Continued From page 30
(erosion) through the penis shaft along the underside of the [redacted] caused by the [redacted] [redacted]. Staff A said the channel was red as if it had not had time to heal.

On 5/3/13 at 9:05 a.m. Staff A called Staff K at home. Staff K is the nurse who changed the urinary catheter on 1/19 and 4/20/13. Staff K did not recall changing [redacted] on 4/20/13 and said she noticed nothing abnormal about Resident #95's [redacted] or [redacted].

On interview 5/3/13 at 9:20 a.m. Staff S stated that she performed catheter care daily which included washing the resident's penis with soap & warm water, rinse, and dry. Staff S stated that she did not notice changes in the head of Resident #5's [redacted] opening. Staff S said that Resident #95 uses a leg strap for the [redacted] but when he slides to the edge of bed - it stretches and if it hurts, the resident lets staff know. Staff S said she thought the leg strap was used to keep the catheter from pulling out. Staff S had never heard of [redacted] tissue eroding due to pressure from [redacted] tubing.

On interview 5/3/13 at 11:47 a.m. Staff A said she inspected Resident #95's [redacted] earlier that morning. According to Staff A she determined that there was an open channel on the underside of Resident #95's [redacted] with an opening at the base caused by [redacted] pressure from the urinary catheter. Staff A stated if looking at the penis straight on, the opening at the base at 6 o'clock straight down (using the face of a clock as directional measure). Staff A said when she looked, there was not a whole lot of play in the [redacted] tubing (not adequate slack). Staff A

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F 315 Continued From page 31 stated "There is teaching to be done."

On 5/3/13 at 10:52 a.m. Staff A measured and documented in the record "from where the [redacted] opening ends to the tip of erosion is 2.3 cm (centimeters) area is red in color with a 1-2 mm (millimeter) area at the base of the erosion that appears white/yellow in color and the area surrounding is red."

The facility staff failed to prevent, recognize or address skin damage related to pressure from catheter tubing resulting in tissue damage to Resident #95's [redacted]

F 315

F 325 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE
SS=D

Based on a resident's comprehensive assessment, the facility must ensure that a resident -

(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and

(2) Receives a therapeutic diet when there is a nutritional problem.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to ensure that one of three residents (#35) reviewed for nutrition maintained body weight. Failure to ensure the

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F 325	<p>Continued From page 32</p> <p>facility policy concerning unplanned weight loss was implemented placed the resident at risk for weight loss.</p> <p>Findings include:</p> <p>Facility policy defined severe weight loss as greater than 5% in 30 days. It also included guidelines about monitoring resident nutritional status. Weight is one of the indicators identified. Policy noted the physician would establish parameters for monitoring weight.</p> <p>Resident #35 was admitted to the facility on 1/17/13 with multiple medical diagnosis including hypertension and diabetes. The initial Minimum Data Set (MDS) assessment dated 1/17/13 documented the resident was on an altered texture diet and weighed 150 pounds.</p> <p>The care plan noted the resident was at risk for aspiration, was provided an altered texture diet and needed set up and supervision for meals. The resident weight record noted that on 1/28/13 the resident weighed 134 pounds. The record documented the resident lost 16 pounds since admission.</p> <p>Review of the clinical record found the Registered Dietitian completed an initial assessment on 1/23/13. The assessment noted the resident had "variable weights" and noted the resident currently had no meal enhancements or nourishments in place. The Dietitian added some meal enhancements to increase calorie intake. The dietitian indicated she would follow up and monitor the resident.</p>	F 325	<p>F325</p> <ol style="list-style-type: none"> 1. Resident 35 no longer resides in the facility 2. All residents will be weighed per facility P & P or MD order. Residents with identified significant changes in weight will be assessed per P & P 3. P & P for weights and nutrition was reviewed and revised as needed. Staff responsible for the assessment of nutritional status were inserviced 4. DNS or designee will ensure compliance by reviewing weekly weight reports. Findings if any will be reviewed and evaluated as part of the facility on going QA/CQI process 	5-24-13

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F 325	<p>Continued From page 33</p> <p>Record review found no evidence the resident was ever reevaluated to determine if the interventions implemented were effective. In addition there was no evidence the facility monitored the residents weight after identifying a weight loss of 16 pounds, which was more then 10 % of the resident body weight in 15 days.</p> <p>On 05/04/13 at 9:30 am, Staff B (the Director of Nursing Services) was asked about nutritional care. After reviewing information documented in the clinical record he agreed Resident #35's weight was not monitored nor was the resident reevaluated. He stated the resident nutritional status should have been reviewed, but he was not able to find any documentation the resident was reevaluated.</p> <p>Not ensuring the resident weight was monitored and/or re-evaluated placed the resident at risk for additional weight loss.</p>	F 325		
F 332 SS=E	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure that it is free of medication error rates of five percent or greater for 2 of 5 residents (#65, #95) observed during</p>	F 332		

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F 332 Continued From page 34
medication pass. Residents received incorrect doses or application of medications 15.6 % of the time (5 errors in 32 medication pass opportunities). This placed residents at risk for adverse side effects or less than intended results from prescribed medications.

Findings include:

RESIDENT #65:

During morning medication pass on 5/2/13 at 8:30 a.m., Staff I was observed to give Resident #65 the following medications immediately after breakfast:

- ~~Keppra~~ 1000 mg 1 tablet crushed. Staff I stated that it was O.K. to crush ~~Keppra~~
- ~~Keppra~~ 88 mcg (micrograms) 1 tablet
- ~~Keppra~~ 125 mg/5 ml 6.4 ml (milliliters) or 160 mg (6 ml drawn first into a syringe followed by 0.4 ml)
- ~~Keppra~~ 315 mg with ~~Keppra~~ 200 IU (International Units) 2 tablets (total dose 630 mg)
- ~~Keppra~~ with ~~Keppra~~ 400 IU

Consultant Pharmacy record review dated 4/21/13 stated "Please note the following medications CAN NOT BE CRUSHED: Keppra".

On interview 5/2/13 at 5:11 p.m. Staff B (director of nursing) stated ~~Keppra~~ is usually scheduled for 11:00 a.m. so that it is given on an empty stomach, but was scheduled incorrectly to be given with morning medications.

Record review found Resident #65 was prescribed 150 mg ~~Keppra~~ (6 ml) for the a.m. dose, not 160 mg (6.4 ml).

Record review found Resident #65 was

F 332

F332

1. Resident 65 was incorrectly identified as the resident effected by the errors in medication administration. The correct resident #74 no longer resides in the facility. The order for resident 95 was revised
2. All other residents receiving the correctly prescribed medications in the correct dose, form and route of administration.
3. Staff I was in serviced on giving the correctly prescribed medications using the 5 right of administration.
4. DNS or designee will ensure compliance by randomly reviewing medication administration.. Findings if any will be reviewed and evaluated as part of the facility on going QA/CQI process

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505462	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/03/2013
NAME OF PROVIDER OR SUPPLIER ANDERSON HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 17127 15TH AVENUE NORTHEAST SEATTLE, WA 98155		
(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 332	Continued From page 35 prescribed Calcium Citrate 315 mg with Vitamin D 250 IU 2 tablets on 3/31/13 (total dose 630 mg Calcium Citrate with Vitamin D 500 IU). RESIDENT #95 During skin check observation, 5/2/13 at 1:31 p.m. Staff I was observed to apply [redacted] (Miconazole Nitrate - an antifungal cream) to skin the resident's [redacted]. There was no redness, or irritation or odor to indicate the resident had a fungal infection. Observation of the [redacted] cream container found prescription directions: 1/28/14 Miconazole Nitrate 2% cream apply topically to [redacted] every shift. On interview 5/2/13 at 2:30 p.m. Staff I said that she applied [redacted] cream to the resident's [redacted] because he has redness that comes off and on "it comes and goes." Review of skin assessments and progress notes found no documentation of [redacted] rash, infection or condition. On interview, 5/2/13 at 5:11 p.m. Staff B (director of nursing) stated that [redacted] Cream is used to treat a [redacted] and is not usually applied over intact skin. According to Staff B, the [redacted] cream was prescribed for the resident's rectal area, not his [redacted].	F 332		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of	F 431		

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F 431	<p>Continued From page 36</p> <p>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 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, interview and record review, the facility failed to store all drugs and biologicals under proper temperature controls and</p>	F 431	<p>F431</p> <ol style="list-style-type: none"> 1. No specific residents were cited 2. All medications were reviewed to ensure they were correctly dated, stored, labeled and discarded 3. Staff responsible for checking the temperature and contents of the refrigerators were in serviced . Staff also in serviced on the P & P for medication storage, dating, labeling, and discarding expired or discontinued medications 4. DNS or designee will ensure compliance by reviewing the temperature logs and medication storage areas... Findings if any will be reviewed and evaluated as part of the facility on going QA/CQI process 	<p>5-24-13</p> <p>RECEIVED MAY 23 2013 DHS/ADSAROS</p>
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F 431	<p>Continued From page 37</p> <p>failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles in 4 of 6 medication/biological storage areas. This placed residents at risk for receiving expired or ineffective or incorrect medications and biologicals.</p> <p>Findings include:</p> <p>Central medication storage for the facility was reviewed with Staff B (the Director of nursing) on 4/29/13 from 8:13 to 8:30 a.m. Observation noted the following:</p> <ul style="list-style-type: none"> -One sealed bottle calcium carbonate 96 tablets expired 6/2012 -Insulin Novolog dispensed 10/31/12 for a former resident (#9) -Lantus Insulin dispensed 4/10/13 for a resident who was never admitted. -Three kinds of eye drops: Latanoprost 0.005% ; Xalatan, Dorzolamide/Timolol 0.5%-2% (cosopt) for a former resident (#13). -An open, undated vial of Influenza Virus Vaccine 5 ml (expiration date June 2013) <p>Review of the medication refrigerator log listed optimal range for medication temperatures as 32 to 41 degrees Fahrenheit. The log stated on the bottom "Please report readings that do not fall in optimal ranges to a manager or a supervisor". Review of the April 2013 medication refrigerator log found nursing staff did not document refrigerator temperatures on 11 of 28 days (1, 2, 3, 4, 7, 15, 16, 17, 22, 23, 24). Staff documented temperatures out of range on 8 of 17 days temperatures were recorded. Out of range temperatures were from 42 to 45 degrees.</p>	F 431		
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F 431	<p>Continued From page 38</p> <p>Review of the specimen refrigerator in the utility room found 2 filled undated blood tubes (purple/green top). The specimen refrigerator temperature was 50 degrees. There was no log of temperatures for this refrigerator.</p> <p>On interview during medication storage review on 4/29/13 from 8:13 to 8:30 a.m. Staff B stated Influenza Virus Vaccine and Insulin should be labeled when open. According to Staff B, he received no report that medication refrigerator temperatures were outside of identified parameters. Staff B said there was never a log for the specimen refrigerator, "don't know, never thought about it." Staff B did not know if the undated blood specimens required refrigeration.</p> <p>Staff B stated a staff person was assigned to keep all medications and biologicals current and dispose of outdated or unused medications and biologicals on a weekly basis. According to Staff B, he was responsible to ensure that medications and biologicals were checked and met storage parameters. Staff B stated that he was responsible to ensure that the medication refrigerator was monitored and maintained within accepted parameters (32 to 41 degrees). Staff B stated "no excuse, (it was) not checked."</p> <p>Review of the North Hall Treatment cart on 4/29/13 at 4:26 p.m. found: -a 1/2 used tube of diclofenac sodium topical gel dispensed 2/16/13 for a former resident (#70) -Betadyne (Iodine solution) - one 16 oz bottle approximately 1 oz used with no name, no date and dried drips on side. -Dakins 0.25% solution liquid 1/2 strength</p>	F 431		<p>RECEIVED MAY 23 2013 DHSA/OSAI/CS</p>

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F 431	Continued From page 39 dispensed 1/4/13 for a resident no longer in the facility (#77) Review of the North Hall Medication cart on 4/29/13 at 4:48 p.m. found: -One vial Humulin R U-100 insulin and one vial Humulin N-100 for Resident #65 with no open date. On interview, Staff B stated that the insulin should be dated when opened.	F 431	F441 1. The staff caring for resident 12 was in serviced on the P & P for glove changes and hand washing. 2. All residents are at risk for potential spread of infection from improper hand washing and glove changes	5-24-13
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; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441	3. Staff o was in serviced on the P & P for hand washing and glove changes 4. DNS or designee will ensure compliance by direct observation of care as part of the facility infection control rounds Findings if any will be reviewed and evaluated as part of the facility on going QA/CQI process	RECEIVED MAY 23 2013 DSHS/ACLA/ROS

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F 441	<p>Continued From page 40</p> <p>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 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, interview and record review, the facility failed to ensure that all staff followed facility policy and accepted professional practice related to washing hands after direct resident contact. This placed all 26 residents at risk for increased infection.</p> <p>Findings include:</p> <p>Facility policy stated "all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors."</p> <p>Facility hand washing practice identified: employees were required to wash hands for at least 15 seconds with soap and water after contact with a resident's body fluids or excretions and after handling soiled or used linen, catheters, soiled equipment or utensils. Alcohol-based hand rub may be used after removing gloves. Use of gloves does not replace hand washing/hand hygiene. Hand hygiene is always the final step</p>	F 441		

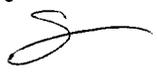
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F 441	<p>Continued From page 41</p> <p>after removing and disposing of personal protective equipment. The policy reflected accepted professional practice to prevent spread of infection.</p> <p>Observation of unassisted care for Resident #12 by Staff O on 5/2/13 at 1:55 p.m. noted the following: Staff O gathered supplies, including a clear plastic bag available for soiled incontinence wipes and pads. After donning gloves, Staff O cleansed the perineal starting at the insertion site with an incontinence wipe which was then discarded. After cleaning the perineal area, Staff O had Resident #12 turn to the side. Staff O wiped Resident #12's perineal cleft 3 times, removing smears of bowel movement from the area, discarding the soiled wipes into the prepared plastic bag.</p> <p>Without removing or changing gloves, Staff O applied the new incontinence brief, repositioned the resident placing pillows per resident preference and tied the plastic bag closed. Without removing or changing gloves, Staff O retrieved a urine measuring container and emptied the urine of urine. Without removing or changing gloves or washing hands, Staff O poured out the urine into the toilet bowl, placed the measuring container into a plastic bag and tied the bag shut. Staff O then removed gloves most way, with fingers tips still in gloves holding onto the two closed plastic bags (measuring container and soiled incontinence pads).</p> <p>Without removing gloves or washing hands, Staff O carried the bag with the soiled measuring device and garbage to a dirty utility room and left</p>	F 441		

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F 441	<p>Continued From page 42</p> <p>the garbage there. Without removing gloves or washing hands, Staff O walked to the utility room, opened the door through the clean side, walked across and disposed of the measuring device in bag on shelf w/other dirty supplies to be cleaned. Staff O then washed hands at sink.</p> <p>On interview 5/2/13 at 2:05 p.m. Staff O said she changed gloves if they were soiled. According to Staff O, her gloves were not dirty, so were not changed after wiping the resident's bottom.</p> <p>Staff O did not follow facility handwashing policy. She touched the urine collection system with contaminated gloves. She contaminated Resident #12's environment and the clean utility door handle prior to washing hands, placing all residents at risk for infection.</p> <p>This information was reviewed with Staff A and B 5/2/13 at 5:20 p.m. Both agreed that Staff O should have changed gloves and practiced hand hygiene after wiping Resident #12's bottom.</p>	F 441		
F 514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and</p>	F 514		<p>RECEIVED MAY 23 2013 DHHS/ACTV-13</p>



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F 514	<p>Continued From page 43 services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized to adequately document monitoring or pressure ulcers, skin tears, or skin conditions for 1 of 3 residents (#95) reviewed for pressure ulcers. This resulted in inability to determine monitoring or resolution of skin issues, resulted in failure to identify when the resident developed soft tissue injury to his penis and resulted in application of anti-fungal medication after an infection was resolved.</p> <p>Findings include: On interview 4/29/13 at 4:15 p.m. Staff A (Administrator) stated that the facility documentation system was "fractured" and staff was transitioning into an electronic record when she was hired in the Fall 2012. Staff A stated that in December 2012 she realized assessments were not available, so trained staff in the correct process. According to Staff A, if a skin problem was identified, nurses were directed to document on the Treatment Administration Record (TAR) - for no issues, + for skin issues. For + issues nurses were to document a separate skin assessment, and document a progress note and treatment summary.</p>	F 514	<p>F 514</p> <ol style="list-style-type: none"> 1. The clinical record resident 95 will have complete accurate documentation of all skin issues. 2. All residents will have clinical records that are complete and have accurate documentation of any skin issues 3. LN staff in serviced accurate documentation and following the P & P for skin assessment. 4. DNS or designee will ensure compliance by random audit of the clinical record Findings if any will be reviewed and evaluated as part of the facility on going QA/CQI process 	5-24-13

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F 514	<p>Continued From page 44</p> <p>On interview 5/2/13 at 12:46 p.m. Staff B (Director of Nursing) stated skin documentation notes from December/January may be multiple and not complete as staff was learning the system. Documentation records included the TAR and Progress notes.</p> <p>Medical record review found Resident #95 was re-admitted to the facility 12/27/13 after hospitalization 12/12/12 for [redacted] related [redacted] (urinary tract infection). Resident #95 returned to the facility with a [redacted] draining his bladder and a [redacted] (tube inserted into the [redacted] to [redacted] directly from the [redacted]). Facility treatment records showed the nephrostomy tube was discontinued 1/28/13.</p> <p>Resident #95's admission Minimum Data Set (MDS - an assessment tool) dated 12/27/12 identified the resident had one Stage 1 or greater pressure ulcer. (Pressure ulcers are "Staged" from I-IV with Stage I being non-blanchable redness of intact skin and Stage IV being full thickness tissue loss with exposed bone, tendon, or muscle).</p> <p>Initial skin assessments were as follows: -12/20/13 admission note: scattered bruising on both sides of upper and lower extremities (arms and legs). No measure or quantification. -12/25/12 weekly skin assessment Stage I coccyx pressure ulcer 4 x 3 cm, present on admission -12/25/12 weekly skin assessment 7 x 5 cm swelling without stating location, present on admission -1/1/13 coccyx 4.2 x 3.6 cm Stage I, left elbow</p>	F 514		
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F 514	<p>Continued From page 45 remains swollen (not quantified) -1/1/13 L elbow swelling 7.2 x 5.8 cm, abdomen bruising 0.8 cm x 1.1 cm, pressure pressure 4.2 x 3.8 cm and bilateral bruising on arms and legs (not measured or quantified)</p> <p>No other documentation of wound, bruise or injury progress was found until March 2013 (2 months later). Nursing skin assessments for the coccyx Stage I pressure ulcer on 3/5, 3/23, and 3/26/13 identified redness on the area area, without quantifying the amount or area of redness or consistently identifying if the redness was a rash, skin irritation or due to pressure. Review of electronic skin assessments and progress notes found no other measurements or documentation of skin condition regarding left elbow swelling or bruising on the abdomen. A progress note dated 1/12/13 identified "bruises resolving on the right and left lower arms."</p> <p>Treatment Administration Record (TAR) for January-March 2013 found staff documented monitoring and/or care of identified skin areas one or more times per day including: -Mepilex or equivalent foam dressing to coccyx every 3 days and as needed -Monitor multiple bruises on both upper and lower extremities until resolved -Monitor bruise on left lower abdomen until resolved -Weekly skin assessment via skin assessment tab. -Monitor Nephrostomy tube site on left flank for symptoms of infection until healed (order 1/28/13) -Monitor swelling on left inner elbow until further order obtained -Heel lift boot to right foot when in bed,</p>	F 514		
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(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
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F 514 Continued From page 46
Information only - right heel ulcer (order 10/11/12)

There was no measuring or quantifying the skin injuries or indicating if they were resolved. The only discontinued monitoring was the ~~site~~ site on left flank on 3/13/13. The remaining monitoring documentation continued through mid-April 2013, including the "right heel ulcer" for which there was no quantifying information.

March/April 2013 Progress notes documented new skin injuries. Skin assessments were used by staff to document if the injury was healed but not to quantify injury or healing progress:
-3/5/13 2 x 2 cm open area left lateral leg - cleansed and applied dry dressing (healed 4/15/13)
-3/23/13 6.5 cm U-shaped skin tear on left elbow with 5 x 3 cm bruising above the area, change dressing every evening until resolved (healed 4/8/13)
-4/11/13 coccyx abrasion 3 x 3 cm, cleansed and applied foam dressing (healed 5/2/13)
-5/2/13 buttocks and groin red but not open (no measure)

Progress note review found an entry "2/6/13 the resident had few drops blood from penis due to pulling on the catheter tube." Weekly skin assessments documented by nurses identified no penis or related catheter problems in February, March or April 2013.

Observation 5/2/13 at 1:12 p.m. noted Resident #95's ~~urinary catheter~~ looked as if it was coming out the side of the ~~penis~~ or from the ~~penis~~, not from the end of the ~~penis~~. Investigation found

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505462	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/03/2013
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that a 2.3 cm channel had eroded through the skin of the resident's penis due to pressure from the [redacted]. Even with weekly skin checks by nursing staff, no one reported or documented seeing or knowing of this injury. See findings under Code of Federal Regulations (CFR) 483.25(d)(1)(2) and 483.20 (k)(3)(i).

On observation 5/2/13 at 1:31 p.m. Staff I came to Resident #95's bedside and applied [redacted] (prescribed [redacted] cream) to the resident's [redacted]. There was no observed rash or infection. Staff I did not recognize that the resident's skin no longer required application of [redacted] medication. See findings under CFR 483.25(m) (1). No where in the progress notes or skin assessment was there documentation that the original fungal rash had healed.

Findings regarding lack of skin assessment and documentation in the electronic record was reviewed with Staff B on 5/2/13 at 4:40 p.m. Staff B acknowledged the lack of documentation, stating that using the electronic charting system was a "work in progress."

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