

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

PRINTED: 07/16/2014
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 07/01/2014
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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 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced State Off Hour Quality Indicator Survey and abbreviated survey conducted at Anderson House Skilled Nursing Facility on 06/23/14, 06/24/14, 06/25/14, 06/26/14, 06/27/14, 06/30/14 and 07/01/14. Data collection included the morning hours on 06/27/14 between 4:45 and 8:00 a.m. A sample of 26 residents was selected from a census of 29. The sample included 19 current residents, the records of 7 former residents and 2 supplemental residents.</p> <p>The following complaint was investigated as part of the survey #30114032</p> <p>The survey was conducted by:</p> <p>Robin Windhausen, MS, R.D Mavis Kankomba, RN, BSN Barbara Jackson, RN, BSN Sharon Stephens, RN, BSN</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Long Term Support Services Administration Residential Care Services, Region 2, Unit E 20425 72nd Avenue South, Suite 400 Kent, Washington 98032-2388 Telephone: (253) 234-6000 Fax: (253) 395-5070</p> <p><i>Residential Care Services</i> <u>7-16-2014</u> Date</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Angela Cerna</i>	TITLE Executive Director	(X6) DATE 7/25/14
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F 225	<p>F-225</p> <ol style="list-style-type: none"> 1. Resident #136 no longer resides at this facility. 2. MDS Coordinator will be in-serviced on ensuring MDS match what care plans state and nursing documentation 3. Training with all LN and Care Managers on steps to complete a proper A&I. More specific and descriptive on summaries and interventions. Thorough skin checks on resident at time of injury and post with documentation follow-through. Environmental physiologically and situational observations need to be documented and as well. Facility will implement Post-Occurrence Assessment as a follow up system that will be managed by the DNS after every incident that occurs. 4. Facility shall monitor for on-going compliance by DNS 24-48 hours after incident to ensure on-going compliance. 5. Results will be brought to QA quarterly. 6. Completion date of 08/19/14. Director of Nursing and Administrator are responsible for compliance. 	

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F 225 Continued From page 2

F 225

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to provide evidence incident reports were thoroughly investigate for 1 of 4 Residents (#:136) reviewed for incident of abuse and neglect. The failure placed residents at risk for further incidents or abuse and neglect.

Findings included:

RESIDENT # 136

Resident 136 was admitted on [REDACTED] 14 with diagnoses which included muscle weakness and difficulty ambulating. The most recent Minimum Date Set (MDS), a facility assessment, revealed the resident had poor recall of events. The initial nurses assessment dated [REDACTED] 14 revealed the resident required limited assist for transfers and ambulation.

The first three days during the survey, Resident 136 was observed ambulating with a front wheel walker, independent of and with staff wearing loose fitting house shoes. His feet lifted out of the shoes as he walked. There was an inch or greater gap between his foot the shoes. The resident was also observed on two separate days of the survey wearing pants which did not fit and would fall down around his hips. The resident had a raised bump (around the size of a golf ball) on the top, right of his head and cuts over his right

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F 225	<p>Continued From page 3</p> <p>eyebrow with strips of dressings like tape.</p> <p>On 06/23/14 at 12:53 p.m., Staff E, a licensed nurse, stated the resident had a fall on the night shift, shortly after the day of his admission to the facility.</p> <p>Review of the fall investigation report revealed a fall occurred on 06/16/14 at 3:27 a.m. The report revealed the resident was found sitting down on the floor, leaning on the right side of the bed, facing the entrance door to the room. The resident reported no pain and was very quiet. The resident reported he got up the wrong way. Resident 136 was confused, drowsy and had a bruise around the right eye from the fall. The record also revealed an assessment of the right eyebrow included a 1.0 centimeter (cm) and a 1.5 cm open wounds.</p> <p>Although first aid was administered, the investigation report did not reveal how the eyebrow injury occurred or what the resident may have hit his head on. The report also did not reveal other possible contributing factors in the fall such as; furniture placement, the clothing worn i.e., foot wear, socks, shoes and /or loose fitting pants. There was no statement from the staff who was assigned to care for the resident. The report did not reveal when the resident was last observed by staff or where the call light was when the resident was found, which may have been contributing factors in the fall and would have been instrumental in a care plan to prevent further falls.</p>	F 225		

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F 225 Continued From page 4

On 06/27/14 at 6:00 a.m., the missing investigation information was pointed out to the Director of Nursing. Additional information or an addendum to the fall investigation was provided later the same day.

Review of the investigations revealed the resident had another fall which occurred on 6/24/14 at 4:00 a.m. The report revealed staff notice a bump over the right top of the resident's head. The resident could not recall what happen. As part of the investigation, in a later interview, the resident reported he found himself on the floor, under the bed and he scratched his head on the springs under the bed.

The investigation did not reveal whether the springs under the bed could have caused a golf ball size raised area on the resident's head, which later resulted in a black eye. The investigation also did not reveal where the call light was, provide a caregiving staff statement of events leading up to the fall, when the resident was last observed by staff, what the resident was wearing or other possible factors which may have contributed to the fall and injuries. The investigation was also not clear on how abuse and neglect had been ruled out.

06/26/14 at 10:00 a.m., in interview, Staff F, the charge nurse stated the Resident's loose fitting house shoes were appropriate fitting foot ware because resident was able to walk in them. However, the following day, on 6/27/14 at 00:42 a.m., the resident had another fall.

The fall investigation revealed the nurse found

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F 225	<p>Continued From page 5</p> <p>the resident on the floor in front of the love seat by the nurses station. The resident had a head injury (bleeding from the back of his head) and was sent to the Emergency Room. The resident reported "I slid off."</p> <p>It was not clear how sliding from a love seat, which had padded arms would cause a head injury sever enough to be sent to the hospital. The report did not reveal what position the resident was in when staff found him, whether he had on proper fitting foot ware as care planned, if he had his walker and it did not include a statement from the caregiving staff.</p> <p>Without a thorough investigation to include contributing factors of a fall, it would be difficult to ruled out abuse and neglect and protect the resident from further harm.</p>	F 225		
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview review the facility failed to ensure residents were provided a dignified dining experience for 4 stage II sample resident's (#84, #51, #6,</p>	F 241		

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#136,) and two supplemental residents (#144, #145). Failure to ensure the meal service was provided in a manner which enhanced resident dignity and individuality could negatively impact the residents' quality of life.

Findings include:

On 06/23/14 from 12:10 to 1:00 p.m. the following observations were noted;

At 12:14 approximately 7 or 8 residents seated in the dining room for the noon meal, two meal trays were observed on the counter. Although the residents were waiting for the meal to be served, none of them had been offered beverages while they waited for the meal.

The only staff present in the dining room, a Nursing Assistant, Staff G was observed offering to assist residents with placement of a clothing protectors.

Resident #84

At 12:16 p.m., a meal tray was delivered to Resident #84. The resident refused the meal when the plate cover was removed. Staff G served the other items from the tray: which included apple sauce, a glass of milk, and a glass of water. The resident readily consumed the applesauce. The staff did not offer or ask the resident if he wanted an alternative meal at the time he refused.

At 12:36 p.m., Staff G offered an alternate meal to resident #84 a salad, however the resident declined. The resident then gestured he wanted

F 241

F-241

1. C.N.A. assigned to dining room will offer beverages before meal services and ensure we are serving 1 table at a time.
2. Alternative meals will be offered to residents if they decline the current menu in a timely matter. Other food choices that resident request, check with nurse on appropriateness. Resident still has right to eat other items despite the risk, however they may need to be informed of risk and benefits and MD may need to be notified.
3. Ensure adequate support in the dining room during meal times to ensure continual assistance happens with no interruptions.
4. In-service on ensuring meals are consumed and if refused nurse needs to be notified so that they can have alternates replacements.
5. Plate warmers have been ordered for the facility to ensure temperature of food remains at proper temperature.
6. Facility shall monitor for on-going compliance – meal supervision x2 weeks and monitored weekly by nurse managers.
7. Completion date of 8/19/14. Director of Nursing and Administrator are responsible for compliance.

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F 241	<p>Continued From page 7</p> <p>a " cookie " , he observed at his tablemate place setting. Staff G, then alerted the nurse of the request. The Nurse, Staff E entered the dining room and verbally advised the resident the item he had requested was not allowed on his diet. The resident remained in the dining room, but was not offered any other alternative to the meal.</p> <p>Resident's #51 and #6 At 12:20 p.m., Resident #51 and #6, were seated together at a table sleeping when their trays arrive. At 12:28 p.m., Staff G pushed Resident #6, who was seated in a wheelchair, out of the dining room. The resident had not consumed any of the meal that was served. During the next 20 to 30 minutes the resident remained sleeping in a wheelchair outside the dining room sleeping.</p> <p>Staff G returned to the dining room and began to assist Resident #51, who was awakened after verbal cuing. Although Staff G sat beside the resident and began feeding her the meal, the staff left the table to assist other residents on multiple occasions during the next 30 minutes, which interrupted the assistance provided to resident #51.</p> <p>Resident # 136 At 12:24 p.m., Staff G, opened the kitchen door and requested a bowl of soup. At 12:25 Resident #136, was assisted into the dining room and seated at a table. Resident # 136 was observed sleeping at the dining room table at 12:30, and he had not received a tray. At 12:37 an unnamed staff member entered the dining room and asked where the Resident #136's lunch tray was and then exited the area to locate the tray.</p>	F 241		

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F 241	<p>Continued From page 8</p> <p>At 12:47 the unnamed staff returned and delivered a lunch tray to resident #136. The resident pushed the plate away and drifted off to sleep again. At 12:51 Staff G, delivered the bowl of soup to the resident that was requested at 12:24, although the alternate meal was requested prior to the resident entering the dining room it took 25 minutes for the resident to receive the alternate meal he appeared to have requested.</p> <p>During a follow up interview on 06/23/14 at 1:50 p.m., Staff G was asked about the noon meal. She reported Resident #6, never returned to the dining room for the meal. She explained the resident would be offered additional nourishment later in the day.</p> <p>During the observation residents waited extended periods of time for assistance after the meal trays or assistance was provided. Even though the staff assisted Resident #51 within several minutes of the tray being delivered, the assistance was repeatedly interrupted. Resident #6 was taken from the dining room without being offered any food or fluids. Resident #84 refused the meal but was not offered an alternate or replacement meal for approximately 30 minutes. The staff then denied Resident #84's request for a specific food item. Although Staff G requested a bowl of soup for Resident #136, it took approximately 25 minutes after the request was made for an alternate meal was available.</p> <p>In addition, although the residents were gathered in the dining room prior to the meal, none of them were offered any beverages while waiting.</p> <p>On 6/30/14 during observation of dining between</p>	F 241		

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F 241	<p>Continued From page 9</p> <p>7:20 and 7:45 a.m., the following observations were noted;</p> <p>Resident #145 and #144</p> <p>At 7:20 a.m., only one resident, #145 was observed with a breakfast tray. Two staff members were present in the dining room, a Nursing Assistant, Staff H and the Director of Nursing Services, Staff B. On this occasion, some residents who were observed waiting for the meal had already been served beverages (i.e. coffee and/or hot chocolate) while waiting for the meal.</p> <p>Although resident #145, was eating the meal at 7:20 am, Resident #144, who was seated at the table did not. Resident #145 was heard to comment to Resident #144 "are they feeding you today." Resident #144's tray arrived at the table at 7:26 a.m., but by the time it arrived the tablemate, Resident #145 had already finished the meal.</p> <p>Resident #51</p> <p>At 7:30 am Resident #51's tray was served. Although Staff H, sat beside the resident at the table to assist, the Staff left the table to assist others as needed. Staff H return to assist the resident, offering bites of food on several occasions while standing. The assistance provided to resident #51 was repeatedly interrupted. Additionally Resident #144, waited for the meal to be served.</p> <p>Random observation of dining room on 6/25/14</p> <p>Resident # 6</p>	F 241		

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F 241	<p>Continued From page 10</p> <p>On 06/25/14 at 1:16 p.m., Staff G was observed in the dining room. The staff verbally cued Resident #6, to eat by stating here is the " first bite of lunch." When asked about the tray, Staff G, stated Resident #6 ' s meal was delivered to the resident at 12:30 p.m. She stated she had not reheated any of the food items.</p> <p>The resident sat in the dining room for 45 minutes after the meal was set on the table before assistance was provided.</p> <p>On 07/01/14 at 8:00 a.m., the Administrator was interviewed about the food service department. She indicated the facility had identified issues related to the food temperatures and was in process of purchasing a new system for plate warmers. After the discussing the Staff's refusal to honor the specific request for a food item made by Resident #84, the Administrator stated the resident should have been allowed to have the item he requested.</p>	F 241		
F 248 SS=D	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure 2 of 3 Residents (#3 and #80) reviewed during Stage II</p>	F 248		

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Continued From page 11
for activities were provided an on-going program of activities to meet individualized needs. Failure to meet this requirement placed residents at risk for social isolation and a diminished quality of life.

Findings include:

Resident #3 was readmitted to the facility [REDACTED] 13 with multiple diagnoses including anxiety and depression. The last annual Minimum Data Set (MDS) assessment, dated 02/15/14, revealed the resident needed extensive assistance from 2 staff with most activities of daily living. (I.e. transfers, mobility, dressing, grooming and hygiene.)

According to mood interview conducted found the resident reported no issues. The assessment did note cognitive changes and reported the resident had no behavioral issues. The MDS reported preferences for activities documented the resident reported it was important to listen to music, keep up with the news, attend group activities, go outside for fresh air and attend religious activities.

Throughout observations on 06/23, 06/24, 06/25, and 06/26/14 the resident was observed lying in bed sleeping during normal waking hours. At times was easily aroused. The resident did attend meals outside the room, but also had meal trays delivered to her room on some occasions. The only observations of the resident out of her room were when the resident went to the dining room for meals.

According to the most recent annual MDS, dated 2/15/14, reported the Care Area Assessment (CAA) for activities was not triggered or

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- F-248
1. Resident #3 care plan, activities, and CAA was reviewed and updated. Resident #80 no longer resides at facility.
 2. MDS Coordinator will be in-serviced on ensuring MDS match what care plans state and nursing documentation, as well as annual CAA's to be completed on all long-term care residents.
 3. MDS will audit all LTC to ensure compliance in CAA and care plan are up to date.
 4. Activities will audit and ensure all care plans for activities are complete and appropriate going forward on all new admissions. All activities will be documented daily for residents residing within the facility. CAAs will reflect appropriate activity preference for residents.
 5. Facility shall audit for on-going compliance weekly x4 and monthly x3 by medical records.
 6. Results will be brought to QA quarterly.
 7. Completion date of 08/19/14. Director of Nursing and Administrator are responsible for compliance.

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F 248	<p>Continued From page 12</p> <p>completed. The last CAA was completed on 02/17/13. The summary noted the resident had "begun to attend some out of room activities", identified as music; church; and entertainment activities. According to the summary the resident would be escorted by activity staff "to programs daily " and indicated the resident would be monitored for the need for 1 to 1 programing if attendance decreased.</p> <p>According to care plan, dated 05/20/13 identified the resident "had little or no activity involvement. " The interventions stated the resident needed assistance / escort to activity functions. The interventions also indicated the resident's room was located near the nursing station for "increased stimulation." The care plan goal was for the resident to participate in activities of choice 3 to 5 times a week.</p> <p>On 07/01/14 at 10:20 a.m., an interview was completed Staff C, an activities assistant. Staff C, reported their department had just initiated a tracking record for the provision of activities. She stated a record of the provision of activities for Resident #3, was documented in the progress notes.</p> <p>When asked about the preferences the MDS assessment identified, Staff C stated she did not feel it was accurate. She reported even though the resident was frequently invited activities out of the room the resident routinely declined to attend any of them.</p> <p>Staff C, stated she was not certain if the resident had a music player in her room. The staff then checked Resident #3's room for a music player but none was found. When asked if the resident</p>	F 248		

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F 248	<p>Continued From page 13</p> <p>was provided any music in her room, she reported she was not certain.</p> <p>Staff C provided the record of activity participation for June. According to the record the minimum goal of three activity contacts a week was not met for two of the four weeks during June.</p> <p>Not ensuring the resident was offered activities as care planned placed the resident at risk for social isolation and a diminished quality of life</p> <p>RESIDENT #80</p> <p>Resident #80 was admitted [REDACTED] 14 with multiple diagnoses which included Depression. The Minimum Data Set (MDS) assessment tool, dated 12/03/13 identified the resident with a diagnosis of Depression. The Care Plan (CP) dated 01/01/14 also identified Resident # 80 as having a diagnosis of Depression. Review of the Activity Admission Assessment dated 12/04/13, revealed Resident # 80's preferred activities included playing cards, games, listening to music, reading books, watching television, walking or wheeling outdoors talking and conversing.</p> <p>In multiple observations on 06/24/14 between 08:30 a.m. and 10:45 a.m., 06/25/14 between 1:10 p.m. and 3:30 p.m., and 06/26/14 between 11:00 a.m. and 12:00 p.m., Resident #80 was observed laying in his bed with eyes open and was not observed participating in any activities or interacting with any facility staff. Review of the most recent CP dated 01/01/14 for Resident #80, did not include an activities CP.</p> <p>On 06/26/14 at 11:22 a.m., in an interview, Staff D could not tell when the resident last participated in</p>	F 248		

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F 248	Continued From page 14 any activity program. Review of activities progress notes did not include documentation of the resident's participation in any activities. Staff D acknowledged the resident had not participated in any activities. When Staff D was asked, she stated "I just started working here. I'm getting familiar with resident's preferences for activities."	F 248		
F 250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure Social Services were provided for 2 of the 19 current Stage II residents. (#135, #84) Failure to coordinate services for mental health services for one resident (# 84) and implement discharge planning for two residents (#135, #84) placed the residents at risk unidentified and/or unmet care needs. Findings include: Lack of discharge planning RESIDENT #135 Resident #135 was admitted to the facility on [REDACTED] 14 for skilled therapy after the placement of a pacemaker. The initial assessment dated 06/14/14, did not identify the resident's overall expectations for discharge. Even though the interview was done with the resident, the section to document the resident's wishes was blank. The care plan in the clinical record did not identify a</p>	F 250	<p>F-250</p> <ol style="list-style-type: none"> 1. Resident #135 and #84 care plan was reviewed and updated, noting barriers to discharge services planned on assisting resident in achieving goal. Resident's progress notes have been updated to plan for residents discharge, as well as barriers to discharge. 2. Resident #84 was referred to mental health services and activities care plan was reviewed and edited. 3. Facility is implementing new UDA to capture a more thorough discharge plan. Department heads in-serviced on new form. Facility also will print out daily (M-F) updated discharge planning to ensure maintain proper discharge plans on each resident who are not LTC. 4. Department heads in-services on residents with thoughts of self-harm, process to follow and what needs to be implemented to assist the resident. 5. Charge Nurse and DNS will monitor discharge plans and psychosocial issues daily M-F x2 weeks and then monthly x3 weeks. 6. Results will be brought to QA quarterly. 7. Completion date of 08/19/14. Director of Nursing and Administrator are responsible for compliance. 	

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F 250	<p>Continued From page 15 discharge plan.</p> <p>According to observations during the survey Resident #135 ambulated independently sometimes using an assist device. The resident was alert and oriented and when asked reported she was independent with activities of daily living, dressing, grooming, hygiene, mobility and locomotion.</p> <p>According to interview completed on 6/23/14 at 2:30 p.m., Resident #135 reported she planned to return to her own apartment. She stated she planned on returning to her apartment and was anxious to return home. She stated the staff had not discussed any discharge plan and expressed frustration about the process.</p> <p>On 6/25/14 at 12:00 p.m., Resident #135 was observed ambulating around the room independently. She said the facility arranged a care conference with her and her son for the following day. The resident was encouraged to discuss her concerns about discharge planning.</p> <p>According to interview an 6/26/14 at approximately 1:45 p.m., the resident said the care conference meeting had taken place. She reported the therapy staff requested some additional devices, grab bars, be installed in the bath room. She again expressed anxiety about the lack of being able to return to her apartment.</p> <p>According to the progress notes, dated 06/20 and 6/23/14, the resident was upset and wanted to know when she would be discharged home. An entry dated 06/25/14, noted the resident attempted to leave the facility but was redirected back inside by the facility staff.</p>	F 250		
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F 250	<p>Continued From page 16</p> <p>According to the physician's documentation found an entry dated 6/10/14 that stated the resident would be discharged from the facility when approved by therapy. On 06/18/14 the physician noted a conference was needed to clarify potential discharge status. On 6/26/14, the care conference was held.</p> <p>According to an interview with Staff P, a physical therapy aide on 6/30/14 at 9:45 a.m. , the physician requested a home evaluation be completed prior to discharge.</p> <p>Not ensuring a discharge plan was in place that identified the barriers to discharge and how the services were planned and provided to assist the resident in achieving the goal, contributed to the resident expressing frustration and anxiety about not having a discharge plan in place. Not ensuring a discharge plan that identified the barriers to discharge was identified on the residents care plan contributed to the resident expressing anxiety about a pending discharge.</p> <p>RESIDENT # 84 Resident # 84 was admitted to the facility on [REDACTED] 14 with the multiple medical diagnosis and including anxiety and depression. Prior to admission to an acute care facility for treatment for an infection, the resident resided in community based care setting, an Adult Family Home. At the time of admission the resident was receiving Medicare benefits administered by a Health Maintenance Organization (HMO). On 04/06/14, the resident Medicare benefits were terminated, and the HMO deemed the resident</p>	F 250		
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F 250	<p>Continued From page 17</p> <p>was not in need of skilled nursing care and the resident converted to private pay and remained in the facility.</p> <p>According to the initial Minimum Data Set (MDS) assessment, dated 03/26/14, indicated a discharge plan was in place. The assessment indicated the resident planned on returning to the community at the time of discharge and stated the facility would assist in determining what barriers if any barriers to discharge exist. The goal of the care plan was for the resident to return to prior living situation.</p> <p>On 06/23/14 at 12:30 p.m., during the noon meal, Resident # 84 was greeted at the table. The resident reported he wanted to find another facility to live in. When asked if anyone at the facility was helping him look into finding a different facility or care setting he stated no.</p> <p>On 06/24/14 at 9:00 a.m., Resident #84 was observed lying on top of his bed. The resident reported he had moved from out of state to be closer to a family member who was a durable power of attorney. He also reported he felt "stuck" in the facility and complained of boredom.</p> <p>On 6/30/14 at 1:50 p.m., the DPOA was interviewed. She said the resident was hospitalized after becoming ill while residing in an Adult Family Home for approximately two months. At the time of the interview the Resident 's DPOA, stated she was in the process of finding a community based care setting. When asked if the facility staff was assisting her she stated she had been provided the name of a consultant to assist in locating an alternate placement.</p>	F 250		

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F 250	<p>Continued From page 18</p> <p>According to an interview completed on 6/27/14 at 9:30 am, Staff Q, the social worker reported she was not involved in discharge planning for either resident. Staff Q reported she was a newly hired Social Services Director, but had only worked at the facility for about three weeks and had not been involved in any discharge planning for either of the residents.</p> <p>Failure to coordinate mental health services.</p> <p>RESIDENT # 84 According to the initial MDS assessment, dated 03/26/14, the resident reported " thoughts of being better off dead or hurting self in some way " during the initial assessment period. The portion of the assessment intended to identify a safety alert had occurred was blank. The assessment indicated the resident displayed behaviors directed towards others, but documented the behaviors had no impact on the resident's care or the environment. According to the care plan interventions, the resident had behavior problems related to "easily frustrated then yells out and hitting at staff. (Contacts at times)." Several different interventions were identified, that included when resident is frustrated "make sure safe and leave alone" ; and "Provide program of activities that is of interest and accommodates the residents status." During interviews conducted on 06/23, 06/24, 06/25 and 06/26/14, the Resident #84, shared his psychosocial history. The resident expressed grief related to the multiple changes during the past several months. Which included moving to</p>	F 250		

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F 250	<p>Continued From page 19</p> <p>the Seattle area from a different state, a pending divorce, and a new DPOA, who is an adult child. The resident did become sad and teary eyed when he shared the information about his psychosocial history. The resident was noted to attend meals in the main dining room, and between meals the resident was frequently lying in bed watching sports on Television. the resident also complained or boredom</p> <p>According to an interview conducted on 06/30/14, at 1:50 p.m. the DPOA verified the resident psychosocial history reported by the resident was accurate. She also commented the anti-anxiety medication (ordered on an as needed basis) had not been administered recently. She stated she felt the resident's tremors were aggravated by the use of the anti-anxiety medication.</p> <p>The resident reported he had received "counseling" in the past and it was beneficial. When asked if the facility staff had discussed the issue with him, he stated no. The DPOA, who was also present during the interview, agreed the resident might benefit from counseling given all the life changes the resident had experienced during the past year. (i.e. Moving from another state, process of divorce, new DPOA, short term placement in an adult family home and hospitalization.)</p> <p>According to an interview completed on 6/27/14 at 9:30 am, Staff Q, the Social Worker reported she was not involved in discharge planning for either resident. Staff Q reported had only worked at the facility for about three weeks. She stated she was not familiar with Resident #84's psychosocial history.</p>	F 250		

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F 250	<p>Continued From page 20</p> <p>When asked if a referral had been made for any mental health services for Resident #84, she stated no. She then explained the facility had just recently contracted a mental health professional and they would be evaluating the needs for Resident #84.</p> <p>Not ensuring services were provided and/or arranged for a resident who was admitted to the facility with mental health diagnoses, expressed thoughts of self harm, and was identified with behavioral issues placed the resident at risk for not receiving needed care and services to manage mental health issues, including grieving losses.</p>	F 250		
F 272 SS=E	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>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;</p>	F 272		

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F 272	Continued From page 21 Dental and nutritional status; 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 provided assessments for 4 of 28 Residents (#:136,26,135 and 55) reviewed for nutritional supplements, pressure ulcers and dental alterations. The failure placed residents at risk of not receiving appropriated care and services. Findings included: NUTRITION ASSESSMENT: RESIDENT 136 Resident 136 was admitted to the facility on [REDACTED] 14 with diagnoses which included a chronic disease condition exhibited by an increase	F 272	F-272 1. Resident #136 and #55 no longer resides at facility. 2. Resident #26 high protein, high calorie is on the MAR and the amount of intake is being monitored. Weekly skin assessment and measurements are being done and monitored. 3. Resident #135 was offered dental services and was seen by the Denstist on 7/02/2014. 4. All nutritional supplements were moved to the MAR in order to monitor amount of intake more thoroughly. The documentation of output in the flow sheet, it was not accurate as to decide between other fluids vs supplements. 5. DNS and Charge Nurse will check for missing documentation weekly on all residents with high-calories nutritional supplements and skin assessments x 2 weeks and monthly for 3 months. Weights will be monitored weekly or as specifically ordered on on-going basis by the charge nurse, and RD to follow as needed during weekly visits. 6. Nursing staff in-serviced on the accuracy when documenting care area assessments. 7. Results will be brought to QA quarterly. 8. Completion date of 08/19/14. Director of Nursing and Administrator are responsible for compliance.	

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F 272	<p>Continued From page 22 metabolic rate. The resident was also admitted with a right heel wound.</p> <p>The initial Registered Dietitian assessment dated 06/20/14 revealed recommendations for nutritional support which included, begin Ensure (a prescribed, high protein, high calorie, nutritional supplement) for lunch and dinner, give a half sandwich with juice before bed and obtain the resident's weight not less than weekly.</p> <p>In interview, on 06/26/14 at 2:30 p.m., Staff F stated, if there were an order, the Ensure would be documented on the Medication Administration Record (MAR).</p> <p>Record review revealed Resident 136 had shown weight loss. There was a doctor's order which included the Dietitian's recommendations for Ensure.</p> <p>Review of the intake and output flow sheet, the MAR and the treatment record revealed, the amount of Ensure taken by the resident was not being monitored apart from other fluids the resident received.</p> <p>RESIDENT 26</p> <p>Resident 26 was admitted to the facility on [REDACTED] 13. The diagnoses included dysphasia (difficulty swallowing).</p> <p>On 06/14 at 9:00 a.m., the resident was observed in bed eating breakfast.</p> <p>Record review revealed a Registered Dietitian assessment dated 06/13/14 included</p>	F 272		

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F 272	<p>Continued From page 23</p> <p>recommendations for Glucena 8 ounces (a prescribed, high protein, high calorie, nutritional supplement) before bed time for nutritional support.</p> <p>Review of the intake and output flow sheet, the MAR and treatment record revealed, Glucena was not being monitored apart from other fluids the resident received.</p> <p>In interview on 06/27/14 at 07:00 a.m., the DNS stated, orders for high protein high calorie nutritional supplements were not on the MAR and there was no way to currently identify the monitoring of the supplements apart from other fluids the residents received.</p> <p>Without specific monitoring of the amount of nutritional supplement the resident received, it would difficult to assess the effectiveness of the nutritional plan of care.</p> <p>Similar findings for found for Resident 55.</p> <p>WOUND ASSESSMENT:</p> <p>RESIDENT 26</p> <p>Other diagnoses for Resident 26 included, pressure ulcers, secondary to chronic catheter use due urinary retention and muscle weakness. The most recent Minimum Data Set (MDS) revealed the resident required extensive assist with bed mobility or turning and repositioning.</p> <p>Most days during the survey, the resident was observed in bed on his back for breakfast and up</p>	F 272		

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F 272

Continued From page 24 in his wheelchair for lunch.

On 06/23/14 at 01:01 p.m., in interview, Staff E stated the resident had indwelling catheter, pressure related skin erosion and a stage I pressure ulcer on the tail bone area.

The care plan for pressure ulcer included directives for staff to monitor for sign and symptoms of infection, assess the skin condition and measure any redness or open areas.

On 06/30/14 1:30 p.m., Staff F stated weekly skin assessments including measurements which should be on the electronic skin tracking assessment form.

On 06/30/14 at 02:45 p.m., in observation with Staff E, the resident had penile erosion (visible opening along the catheter track). The nurse measured the opened area around 4.0 centimeters (cm) along. The tail bone redness was measured about 4 x 4 cm around and was non-blanchable in the center. Staff E was only able to enter the 4.0 cm measurements in the electronic documentation and no other description of the skin's condition.

Record review revealed the "Weekly Skin Evaluation Assessment" dated 03/12/14, 04/02/14 and 06/25/14, only described the wound condition as being present, redden and the erosion. The assessment did not include all the wounds measurements (the length, width, depth and stage) or other conditions of the wound sites.

Without routine wound assessments, it is not possible to monitor the wounds condition and or provide appropriated care and services as

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F 272	<p>Continued From page 25 needed.</p> <p>RESIDENT #135</p> <p>Resident #135 was admitted to the facility on [REDACTED] 14 after the surgical placement of a pacemaker. The initial MDS assessment, dated completed indicated the resident was alert and oriented, her own decision maker and had lived independently in her own apartment prior to the planned surgery.</p> <p>On 06/23/14 at 2:38 p.m., Resident #135 was interviewed. It was noted the resident upper dental plate was observed to shift position when the resident was conversing. When asked about dental problems, the resident reported a loose fitting denture. The resident commented that she "did not know how the staff could not notice the loose dentures."</p> <p>When asked if she needed assistance from the facility with arranging dental services the resident stated commented she did not "want the staff to have a reason to keep her" in the facility.</p> <p>Although the shifting dental plate was prominent and visible when conversing with the resident the MDS assessment did not note any dental issues were identified. The assessment tool noted there were no dental issues identified.</p> <p>On 06/30/14 at 7:30 a.m., the MDS nurse Staff O, was interviewed about the assessment. She reported the assessment data was documented on the MDS from the initial nursing assessment.</p>	F 272		

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F 272	<p>Continued From page 26</p> <p>She then explained she had met with the resident to talk to her about pain and falls, and commented she did not notice the issue. She then reported a Care Area Assessment was not completed for any dental concerns because the MDS did not identify the issue..</p> <p>The MDS assessment did not accurately describe conditions present on admission that could impact the care and services provided in the facility.</p>	F 272		
F 279 SS=D	<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</p>	F 279	<p>F-279</p> <ol style="list-style-type: none"> 1. Resident #141 and # 142 no longer resides at this facility. 2. Activities staff were trained and will audit to ensure all care plans for activities are complete and appropriate going forward on all new admissions. 3. Charge nurse and DNS will monitor changes in resident conditions and ensure care plans are updated. Medical records will audit to ensure compliance. When residents CAAs are completed MDS will ensure CAAs match the care plans and update as necessary. 4. Facility-wide audit conducted on all residents who use psychotropic medications. Care plans updated to reflect signs and symptoms to monitor, target behaviors, as well as the proper diagnosis. Upon any new admission, this will be monitored and incorporated in care plan and care guides. 5. MDS and DNS will monitor residents with psychotropic medication/s daily M-F x2 weeks and then monthly x3 weeks. 6. Results will be brought to QA quarterly. 7. Completion date of 08/19/14. Director of Nursing and Administrator are responsible for compliance. 	

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F 279	<p>Continued From page 27</p> <p>by: Based on observation interview and record review, it was determined the facility failed to develop a comprehensive care plan care plan with measurable objectives and time time tables for two of nine residents (#141 and # 142) Reviewed for care plans. This failure placed the residents at risk for not attaining the highest practicable, physical and psychosocial wellbeing.</p> <p>Findings Include:</p> <p>RESIDENT #141</p> <p>Resident #141 was admitted in the facility [REDACTED] 14 with multiple health care needs which included palliative care. Minimal Data Set (MDS) an assessment tool dated 6/19/14 identified resident #141 as having a terminal diagnosis and that resident required end of life care. MDS dated 06/19/14 "PREFERENCES for ROUTINE ACTIVITIES" revealed the resident liked to listen to music and attend religious activities. Review of the most recent Care Plan did not include the care plan for Resident # 141 preferred activities. Review of Activities Progress Notes included resident's interactions with activities staff, but did not include documentation of the frequency or duration of scheduled activities.</p> <p>On 06/26/2014 at 11:30 p.m., in an interview Staff B the Activities Assistant acknowledged Resident #141 did not have the activities CP and stated " I'm responsible for making sure all care plan are done, but this was missed."</p> <p>On 06/27/14 at 9:30 a.m., in an interview, Staff C the Activities Coordinator stated " The facility did not have a formal way of tracking resident's</p>	F 279		
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F 279	<p>Continued From page 28</p> <p>participation in activities. We are working on putting together a tracking system to ensure each resident's participation in activities are documented.</p> <p>On 06/27/14 at 10:53 a.m., in an interview with Staff A the facility Administrator, Staff A stated " there has been a problem since the Activity Director left. Now we have an activities coordinator who is learning how to write care plans."</p> <p>The failure to develop an activities care plan with measurable objectives and time lines to meet the resident's psychosocial needs identified, placed the residents at risk for diminished quality of life.</p> <p>RESIDENT 142:</p> <p>Resident 142 was admitted to the facility on [REDACTED] 14. The resident was receiving clonazepam 0.5 milligrams for anxiety and Trazodone (antidepressant) 300 mg at bed time for insomnia.</p> <p>The adverse side effects linked to Trazodone included; weakness, nervousness, blurred vision and ringing in the ears. The adverse side effects for clonazepam (a mood stabilizer) include dizziness, feeling sad, headaches and irritability. Adverse side effects require monitoring as a part of the resident's plan of care.</p> <p>On 06/26/14 at 3:00 p.m., in interview, Staff M, a nurse assistant caring for the resident, was able to locate the care plan directives but found no</p>	F 279		

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F 279	Continued From page 29 target behaviors were identified for Resident 142. When asked, Staff M was not aware the resident had target behaviors of insomnia and agitation. While record review revealed Resident 142 did have care plans developed for other care areas such as; falls, pain and surgical wounds, there was no care plan found with measurable objectives and time lines to meet the resident's anxiety and insomnia needs.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	F-280 1. Resident #137 no longer resides at facility. 2. All adaptive equipment was audited in the building ensuring physician orders matched what residents plan of care states. 3. Audit conducted by Therapy Director and DNS to ensure compliance x 2 weeks and checked monthly x3. In-coming admissions will be monitored by therapy for adaptive equipment orders and ensuring it fits resident need and adjusting via Charge Nurse with physician if changes are to be implemented. 4. All C.N.A.'s were in-serviced to follow all care guides. If it states adaptive equipment needs to be in place, it is to be followed unless clarification is obtained and care guides will then reflect this. 5. Results will be brought to QA quarterly. 6. Completion date of 08/19/14. Director of Nursing and Administrator are responsible for compliance.	

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F 280	<p>Continued From page 30</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to ensure care plans were reviewed and revised when care needs changed for 1 of the 19 (Resident # 137) Stage II Residents who were currently residing in the facility. Failure to ensure the care plan was updated to accurately identify current interventions in place placed the resident at risk for unmet or unidentified care needs.</p> <p>Findings include:</p> <p>Resident #137 was admitted to the facility on [REDACTED] 14 with multiple diagnoses including a history of compression fractures in the spine. The clinical record revealed prior to admission to the facility the resident had a fall and experienced acute back pain. The resident was hospitalized and a medical evaluation ruled out an acute fracture. The resident was admitted to the facility with orders for skilled therapy.</p> <p>The initial Minimum Data Set (MDS) assessment, dated 06/16/14 revealed the resident was dependent on staff for most activities of daily living (i.e. transfers, mobility and locomotion.) The Care Area Assessment conducted in conjunction with the assessment noted the resident had back pain and it "impacts movement."</p> <p>Review of the care plan found a directive stating the resident "wears a back brace for support</p>	F 280		
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F 280	<p>Continued From page 31</p> <p>when out of bed." The physician orders on admission indicated the resident was "to wear back brace at all times when walking or sitting. Brace off when in bed - treatment in a.m., eve, noc (nocturnal shift)."</p> <p>On 6/25/14, the resident remained in bed throughout the day. The resident was greeted in her room at 1:45 p.m., and reported she was not wearing the back brace and stated it was not used when in bed. The resident reported her lunch was served in her room and she remained in bed that day.</p> <p>On 06/26/14 at 10:45 a.m., the Manager of the Rehabilitation department, Staff J was interviewed. She reported the brace was needed if the resident was ambulating and clarified the resident had not been up walking yet. When asked about the physician order to place the device, she stated she was not aware of the order. She then explained the brace had been given to the resident when she was first diagnosed with compression fractures seven years ago. She reported she did not think the device was used and indicated she would look for clarification.</p> <p>On 06/26/14 at 10:55 a.m., a Nursing Assistant, Staff I was interviewed about the brace. She reported the resident did not wear a back brace. She then proposed the therapy staff may be applying it.</p> <p>Between 11:00 am and 11:30 am on 06/26/14, Staff J, the Manager of the Rehabilitation Department and two therapists, an Occupational</p>	F 280		

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F 280	<p>Continued From page 32</p> <p>therapists, Staff K and a physical therapists Staff L assisted the resident with dressing and a transfer. The back brace was not placed; it remained in the seat of a wheelchair beside the bed during the observation.</p> <p>The resident did call out "Ow, Ow, Ow," in a soft low tone of voice repeatedly during the transfer. After placing the resident in a standing frame for approximately 15 minutes. After the therapy session, the therapy staff transferred the resident to a wheelchair. The orthotic brace was never applied.</p> <p>On 06/30/14 at 9:00 a.m., during a follow up interview the Occupational Therapists was asked about the use of brace. Staff K reported they therapists had concerns about the use of device and skin integrity and it was not currently being used.</p> <p>On 6/30/14 at 10:30 a.m., Staff J reported they had just discussed the use of the brace with the Physician, she then stated the order to apply the brace was discontinued. The facility failed to ensure the care plan accurately identified current care needs.</p>	F 280		
F 329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or</p>	F 329		

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F 329	<p>Continued From page 33</p> <p>without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to monitor the effects of mood-altering medications, administer medications in excessive dose and without adequate indication for 3 of 5 Residents (#.142, 84 and 25) reviewed for unnecessary medication use. The failure placed residents at risk of receiving a unnecessary medications.</p> <p>Findings included:</p> <p>RESIDENT 142:</p>	F 329	<p>F-329</p> <ol style="list-style-type: none"> 1. Resident #142 no longer resides at this facility. 2. Resident #25 bowel protocol is being done properly. 3. In-serviced of license nursing staff on proper bowel protocol 4. Behavior monitoring tracking, side-effects and intervention on the monthly flow sheet was initiated upon the initiation of any psychotropic medications for all residents needed. 5. MDS and Licensed Nurses was in-serviced on proper diagnosis associated with use of anti-psychotic medications. 6. Facility-wide audit conducted on all residents who use psychotropic medications. Care plans updated to reflect signs and symptoms to monitor, as well as any target behaviors and parameters for administration. Upon any new admission, this will be monitored and incorporated in care plan and care guides. 7. MDS and DNS will monitor residents with psychotropic medications daily M-F x2 weeks and then monthly x3 weeks. Bowel protocol will be audited weekly x2 weeks and monthly x3 by DNS and charge nurse. 8. Results will be brought to QA quarterly. 9. Completion date of 08/19/14. Director of Nursing and Administrator are responsible for compliance. 	

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FORM APPROVED
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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 07/01/2014
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F 329	<p>Continued From page 34</p> <p>Resident 142 was admitted to the facility on [REDACTED] 14. The resident was receiving clonazepam 0.5 milligrams for anxiety and Trazodone (antidepressant) 300 mg at bed time for insomnia.</p> <p>The adverse side effects linked to Trazodone included; weakness, nervousness, blurred vision and ringing in the ears. The adverse side effects for clonazepam (a mood stabilizer) include; dizziness, feeling sad, headaches and irritability. Monitoring the medications for side effects should be initiated at the time the treatment begins.</p> <p>On 06/27/14 at 9:00 a.m., in interview, Staff N, a medical records staff, stated there was no behavioral monitoring tracking form for the resident.</p> <p>Record review also revealed Resident 142 did not have a "Behavior/Intervention Monthly Flow Sheet" developed to monitor the target behaviors of anxiety and insomnia. In addition, there was no monitoring of the adverse side effects of the medications.</p> <p>Monitoring both the adverse side effects and target behaviors would be needed to assess whether psychoactive medication were necessary.</p> <p>RESIDENT 25</p> <p>Resident #25 was admitted to the facility on [REDACTED] 14, status post traumatic hip fracture.</p>	F 329		
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F 329

Continued From page 35

F 329

A review of the resident's electronic medical record revealed an order for bowel protocol that included Milk of Magnesia (MOM) 30 milliliters one dose as needed, if no bowel movement in eight hours proceed with Bisacodyl 10 mg suppository.

Resident #25's Medication Administration Record revealed the resident was given bisacodyl on 06/19 at 6:51 A.M., and again on 06/22 at 1:20 P.M., however there was no documentation that licensed staff administered 30 ml of MOM prior to administering 10 mg bisacodyl as ordered.

Additionally, the licensed staff administered MOM on 06/24 at 11:18 A.M., and again on 06/25/14 at 5:54 A.M. however, instead of administering bisacodyl as ordered, the licensed nurse administered the MOM on 06/25/14.

On 06/30/14 at 8:36 A.M., Staff B, the Director of Nursing Services, stated "staff failed to follow the bowel protocol

RESIDENT #84

Resident # 84 was admitted to the facility on [REDACTED] 14 with the multiple medical diagnosis. At the time of admission the resident medication orders included three different psychotropic medications including an anti-psychotic, anti-anxiety and anti-depressant.

The initial MDS assessment, dated 03/26/14, indicated the resident was administered an anti-psychotic medication. The diagnoses associated with the use of the medications being administered included anxiety and depression.

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F 329	<p>Continued From page 36</p> <p>Although the assessment indicated the resident was prescribed an anti-psychotic medication, a diagnoses associated with the use of the anti-psychotic was not noted on the MDS..</p> <p>The behavioral section of the assessment noted the resident displayed behaviors directed towards others and also noted the behaviors had no impact on the resident environment and/or the provision of care.</p> <p>The resident's clinical record documented the medications had been ordered and administered since the time of admission. However the clinical record had no evidence the facility had identified the behaviors the medications were intended to treated until [REDACTED] 14, which was approximately 90 days after admission.</p> <p>On 06/20/14, the doctor clarified the order and identified specific behaviors being treated with both medications (an anti-anxiety and anti psychotic) as "screaming and yelling continuously" The order dated 06/20/14, also noted the anti-psychotic medication was administered for a diagnosis of [REDACTED]</p> <p>In addition the anti-anxiety medication was administered as needed, but prior to 6/20/14, the parameters for the administration of the medication had not been identified. The Medication Administration Record (MAR) did not include any instructions for the nurses to identify the symptoms the medication was intended to treat other then "anxiety."</p> <p>The facility failed to ensure there was an appropriate diagnosis associated with the administration of an anti psychotic. In additon,</p>	F 329		
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F 329	<p>Continued From page 37</p> <p>the initial orders included an anti-anxiety medication which could be administered if needed, but the parameters for administration were not identified on the MAR. The facility failed to ensure the behaviors the medication were intended to treat were monitored.</p> <p>These failed practices left the facility and staff without any information needed to assess the efficacy of the medication regime and ensure they were not unnecessary medications.</p>	F 329		

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