

OR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

(E) PLAN OF CORRECTION DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <p style="text-align: center;">505511</p>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <p style="text-align: center;">08/30/2013</p>
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NAME OF PROVIDER OR SUPPLIER <p style="text-align: center;">LEON SULLIVAN HEALTH CARE CENTER</p>	STREET ADDRESS, CITY, STATE, ZIP CODE <p style="text-align: center;">2611 SOUTH DEARBORN SEATTLE, WA 98144</p>
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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
F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Leon Sullivan Health Care Center on 08/20/13, 08/21/13, 08/22/13, 08/23/13, 08/26/13, 08/27/13, 8/28/13, 08/29/13 and 08/30/13. The survey included data collection from 6:00 p.m. to 8:00 p.m. A sample of 46 residents was selected from a census of 149. The sample included 40 current residents, the records of 6 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p> [REDACTED] M.N., R.N. [REDACTED] R.D., M.S. [REDACTED] B.S.N., R.N.. [REDACTED] B.S.N., R.N. [REDACTED] B.S.N., R.N. </p> <p>The survey team is from:</p> <p> Department of Social and Health Services Aging and Long-Term Support Administration Residential Care Services, Region 2, Unit D Creekside Two 20425 72nd Avenue South, Suite 400 Kent, WA 98032-2388 </p> <p> Telephone: (253) 234 6003 Fax: (253) 395 5071 </p> <p style="text-align: right;"> <i>Residential Care Services</i> <u>9-12-2013</u> Date </p>	F 000	<p style="text-align: center;">F170</p> <p>This plan of correction is prepared and submitted because it is required by the State and Federal Laws. Leon Sullivan Health Care Center does not admit that the stated deficiencies on this form exist and reserve the right to challenge these alleged deficiencies. It is Leon Sullivan Health Care Center's policy to ensure residents send and receive mails in a private and timely manner.</p> <p>Corrective action taken for the cited deficiency-F170</p> <p>Resident #130 has been contacted by the Activities Director and was informed that she would be receiving mails daily including Saturdays effective 9/10/2013.</p> <p>Policy and procedures related to receiving/sending and distributing mails have been revised to ensure each resident is able to send and receive mails daily in a private and timely manner.</p> <p>Because all residents are potentially affected by this citation, for resident #130 and others; receptionists and activities department employees have been in-serviced on the revised policy and procedures of residents' mail sending and receiving activities. Per the revised procedures, the receptionist on duty will receive incoming resident mails, sort them out and place them in the activities folder</p>	<p style="text-align: right;">10-10-13</p>

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <p style="text-align: center;"><i>Administrator</i></p>	(X6) DATE <p style="text-align: right;">10-6-13</p>
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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.

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

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 9.23.13
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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 170 SS=D	<p>483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL</p> <p>The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the nursing home failed to ensure mail received by the facility on Saturday was delivered to residents within 24 hours. This failure potentially placed residents at risk for diminished quality of life.</p> <p>Findings include:</p> <p>Review of facility policy of Procedure for Distributing Daily Mail revealed the purpose is "To ensure residents and facility staff receive the proper mail."</p> <p>Procedures includes "Receptionist receives the daily mail and sorts the mail to the following: Personal mail is sorted and put into the activities folder for delivery."</p> <p>On 08/26/13 at 11:30 am during an interview with resident #130, Resident Council President, she stated mail is not delivered to the residents on Saturdays.</p> <p>On 08/26/13 at 1:55 pm during an interview with Staff J, Business Office Manager, she stated mail is delivered by the post office to the facility Monday through Saturday. The Saturday mail is not sorted and passed until Monday. The</p>	F 170	<p>F170 continued located on the first floor daily for delivery. The activities director/designee delivers unopened mails to each resident's room daily. Actions taken to ensure solutions to the cited deficiency are sustained and reoccurrences prevented.</p> <p>The Activities Director will meet with the receptionists, activities department employees and resident counsel president every week X 3 months to discuss the effectiveness of residents' mail delivery system put in place. Depending on the outcome of the meeting, the system will either be modified/alterd or re-enforced. The Activities Director will also inspect mail sorting and distribution visually once a month on Fridays to ensure the process is working effectively. Issues related to mail delivery system will also be discussed in a monthly resident counsel for feedback.</p> <p>Monitoring Activities Director/designee will visually inspect residents' mails folder on the first floor every Monday to ensure there are no mails that haven't been delivered over the weekend. If undelivered mails are found in the mails folder the Activities Director will immediately deliver the mails and investigate reasons why the mails were not delivered. Depending on the outcome of the investigation, the Activities Director will propose</p>	10-10-13
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F 170	Continued From page 2 residents do not receive their Saturday mail until Monday.	F 170	F170 continued	10-10-13
F 241 SS=D	On 08/27/13 at 9:45 am during an interview with Staff A revealed Saturday mail is locked up for safe keeping until it can be delivered on Monday. 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure dining services were provided in a manner that enhanced resident dignity. Failure to ensure staff avoided using terms with negative connotations (i.e. feeder, bibs) and to ensure timely dining assistance was provided to residents. In addition the facility failed to ensure a resident's catheter was maintained in a dignified manner. Failure to ensure care was provided in a dignified manner for 4 of the the 43 (#9, #135), stage II residents, placed them at risk for at risk for a diminished sense of self-worth that could negatively impact quality of life. Findings include: LACK OF TIMELY ASSISTANCE DURING MEALS: On 8/20/13 between 11:00 a.m., and 12:30 during	F 241	The Activities Director will report progress in residents' mail delivery process to the CQI committee every month for evaluation. F241 Providing each resident with dignified, respected and comfortable living environments is Leon Sullivan Health Care Center's policy. The employees believe respect is about being polite, considerate and thoughtful. The facility discourages using terms that can have the potential of negative interpretation and culturally sound insensitive. Corrective actions taken for identified issues. Resident specific Resident#203 is no longer in the facility. Residents #9 &135 are being assisted with breakfast and lunch by the restorative aides. Evening supervisor/on duty LN will assist these two residents with dinner. For resident #52 and others, meal tables are rearranged and set up away from the pillars to avoid obstruction.	

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F 241	<p>Continued From page 3</p> <p>meal observation in the first floor dining room Resident #9 was served at 11:15 a.m., the tray was set on the table before the resident with the cover in place. The resident did not get any assistance from staff with the meal for 15 minutes. Review the most recent Minimum Data Set assessment, confirmed the resident was dependent on staff for eating.</p> <p>On 8/27/13 between 5:00 p.m. and 6:15 p.m. a second observation in the first floor dining room was made. A resident #135 who did not communicate in English, was observed sitting with her meal and not eating. She then spoke in her native language to another visitor in the dining room, who then alerted the staff the resident had requested assistance with the meal. At 6:10 p.m., the visitor confirmed the resident had requested assistance from the staff with the meal in her native language "██████████"</p> <p>On 8/20/13, and 8/23/13 during the noon meal the resident's family member was observed to assist the resident by feeding her during noon meal. The MDS assessment dated 08/15/13 indicated the resident needed limited assistance with dining.</p> <p>POSITIONING OF RESIDENTS AND STAFF DURING DINING:</p> <p>On 8/20/13 during the meal observation Resident #52 was wheeled into the dining room and placed at a table to right of the entry way to the dining room. Although staff attempted to place her chair up to the table, they were not able to. A room pillar physically obstructed the resident from being positioned up to the table in a position to facilitate independent eating. During the</p>	F 241	<p>241 continued</p> <p>All residents are potentially affected by the cited deficiency.</p> <p>For residents #9, #52, #135 and all, under the direction of staff development coordinator:</p> <ol style="list-style-type: none"> 1. All Nurses and Nursing Assistants have been in-serviced on how to use appropriate terms when serving in the dining room. The impact of using terms such as bibs and feeders on the residents' dignity and self-esteem was also discussed in-detail and LNS and NACs verbalized their understanding of possible negative outcome of these terms and promised to avoid using them again. 2. On 9/23/2013, the Operation Manger, Administrator and DON met and discussed dignity and respect issues related to inappropriate use of terms such as bibs, feeders, in the dining room and decided to replace the old clothing protector referred to as bibs by lap/nap kin that can be used in any formal dining rooms. 3. All Nurses and Nursing Assistants have been in-serviced on the importance of assisting residents 	10-10-13

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F 241	<p>Continued From page 4</p> <p>observation period the resident repeatedly pushed the staffs hand away when they attempted to feed her. However after multiple attempts to feed the resident the staff then placed a dish of yogurt on the edge of the table the resident did eat the yogurt independently.</p> <p>Dining observation on 08/27/2013 at 06:18 p.m. revealed Staff S provided feeding assistance to Resident #62 standing at the side of the resident's wheelchair.</p> <p>USE OF LANGUAGE WITH NEGATIVE CONNOTATIONS:</p> <p>On 08/27/13 at 05:45 p.m. with Staff T, NAC, stated some of residents sitting in the small dining area adjacent to the third floor dining room were "feeders". Staff T used the word "bibs" in reference to the clothing protectors worn by residents.</p> <p>FAILURE TO ENSURE A CATHETER WAS MANAGED IN A WAY THAT ENHANCE RESIDENT DIGNITY: RESIDENT #203</p> <p>Resident #203 was admitted to the facility on 08/19/2013 for extensive assistance in daily activities of living due to [redacted] as well as [redacted] services. The resident was 5 [redacted] years old and required an indwelling catheter.</p> <p>An observation made on 08/22/13 at 10:20 a.m. revealed a uncovered catheter bag visible on the side of the bed.</p> <p>Observations on 08/25/13 at 9:50 a.m. and</p>	F 241	<p>241 continued</p> <p>with meals in a timely manner, sitting at the residents' eye level, talking to residents while assisting with meals, and serving residents sitting at the same table first before moving to the next table and covering catheter bags at all times.</p> <p>4. Staff J that failed to sit at the resident's eye level while assisting with meal and staff T that used terms that can potentially impact residents' self-esteem and quality of life have been in-serviced on proper positioning and avoidance of terms like feeders and bibs that can be degrading to others.</p> <p>5. Staff J that failed to sit at the resident's eye level while assisting with meal and staff T that used terms that can potentially impact residents' self-esteem and quality of life have been in-serviced on proper positioning and avoidance of terms like feeders and bibs that can be degrading to others.</p> <p>Actions taken to ensure solutions to the cited deficiency are sustained and reoccurrences prevented.</p> <p>The Lead Aide will make rounds during meal times and observe activities in the dining rooms to ensure dining room policy and procedures are implemented by the nursing staff and continued consistently. The Lead Aide will report his observations/findings in the dining rooms to the residents care managers every morning in stand up meetings. The resident care managers and DON meet once a week and review the nursing Aide's report and make recommendations.</p> <p>Recommendations may include change in procedures, staff education</p>	10-10-13	

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F 241	Continued From page 5 08/27/13 at 3:00 pm revealed the catheter bag in a clear plastic bag laying on the floor under the resident's bed. An observation on 08/29/13 at 9:55 a.m. revealed uncovered foley catheter bag hanging on the side of the bed facing the door. Review of the facility's indwelling urinary catheter protocol noted the drainage bag of a urinary catheter bag was to be secured to the side of the resident's bed frame and cover with a dignity bag.	F 241	241 continued or modification of dining room environments. LNs will be in the dining room for every meal to assist with meals and ensure residents receive the best quality of services, appropriate terms used, meal trays are served in a timely manner, staff and residents are positioned properly during meal time. Night NACS will cover all catheter bags being used with dignity cover and secure them to chairs or beds.	10-10-13
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations and interview the facility failed to ensure care was provided in a manner that accommodated individualized needs of the residents. Failure to ensure that resident call lights were placed in reach left residents without a way to communicate needs to the staff affected 9 of the 149 residents (#71, #139, #82, #141, #52, #17, #99, #33, #89) included in the Stage II sample. FINDINGS INCLUDE:	F 246	Drainage bags should be placed on the side of a bed or chair that is not visible to others whenever possible. Monitoring The staff development or designee will monitor the implementation of the dining room procedures during weekdays by making rounds daily and observing the staff assisting with meals. Weekend dining room activities are monitored by the weekend LNs on each unit. DON will make rounds once a month and observe staff assisting with meals to ensure dining room policies and procedures are implemented. The DON will review Resident Care Managers' Rounding Reports weekly to ensure policy and procedures are implemented as intended. Compliance will further be reviewed in monthly CQI meetings. F246 Leon Sullivan Health Care Center believes that placing call lights within	

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F 246	<p>Continued From page 6</p> <p>Resident # 71 On 08/22/13 at 8:45 a.m., Resident #71 was found in the room seated on a commode chair. The resident gestured to the surveyor for assistance and observed the call light was not within the resident's reach. Review clinical record found the resident was admitted to the facility on 4/29/2013, was cognitively intact and did not communicate in English. The initial assessment also noted the resident was dependant on staff for toileting.</p> <p>Resident #139 On 08/21/13 at 9:05 am Resident #139 was greeted while lying in bed. The resident stated he was ready to call the staff to assist him with dressing and grooming but was not able to locate his call light. The call light was found lying at the end of the bed. When placed within his reach the resident was able to alert staff of the need for assistance. Review of the clinical record revealed the Resident had a progressive neurological disease and was alert and oriented.</p> <p>Resident # 82 On 8/21/13 Resident #82 was found in her room in bed, the call light was not within the residents reach. The resident stated and demonstrated she was able to use the device if available. On 8/30/13 at 9:20 am the resident was again found without her call light in reach. When asked how she could call staff, the resident verbally indicated she could use the call light, but was unable to locate it.</p> <p>Additional random observations on 8/30/13 between 8:45 a.m., and 9:30 found the following call lights on the first and second floor out of reach:</p>	F 246	<p>F246 continued the reach of residents when in bed, chair or bathroom is one of the ways residents' needs are met and injuries are prevented.</p> <p>Corrective Actions taken for identified issues.</p> <p>Resident #71, #139, #82, #141, #52, #17, #99, #33, and #89 had their call lights placed in their reach and LNS and NACS are in-serviced on the importance of making call lights accessible to the resident in bed, chair and bathroom.</p> <p>All residents are potentially affected by the cited deficiency. For residents #71,#139,#82#141,#52,#17,#99,#33,#89 and all, nursing staff has been re-educated on the importance of making call lights accessible to residents in bed, chair, or bath rooms. On 9/13/2013 all residents' call lights were audited by the residents care managers on each unit to ensure call lights were accessible to each resident.</p> <p>Actions taken to insure solutions to the cited deficiency are sustained and reoccurrences prevented</p>	10-10-13

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F 246	Continued From page 7 Call lights were found out of reach for residents #17, #99, #141 and #52 on the first floor. The nurse assigned to the area stated residents #141 and #52 could use and should have the call lights in reach. Resident #17 and #99 stated they used the call light if within reach if they needed assistance from staff. At 9:30 am, on the second floor call lights were found out of reach for resident #20, #33 and #89. Resident #33 indicated she did not know where the call light was located. She reported she was able to use the device if within her reach. Although Resident #89, did not respond verbally he looked for the call light when asked and indicated through gestures he was unable to locate it.	F 246	F246 continued LNs will make call lights checking rounds on their assigned units every day/ every shift to ensure call lights are within the reach of each resident. Day, evening and night LNS will be provided with the daily call lights audit tool that can be utilized. LNS on each unit will report their findings to the resident care managers. Monitoring The Resident Care Managers will make call lights checking rounds once a week on each unit x1 shift and inspect call lights placement visually to ensure call lights are within the reach of residents and policy and procedures related to call light are being implemented effectively. Compliance rounds results will be discussed in a monthly CQI committee meetings to evaluate the effectiveness of the policy and procedure in place.		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES 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. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review the facility failed to provide 1 of 3 residents review for activities, an activity program at the highest practicable level which corresponded with the facility's assessments. This failure had the potential to decrease the quality of life for this resident.	F 248			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

505511

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY COMPLETED

08/30/2013

NAME OF PROVIDER OR SUPPLIER

LEON SULLIVAN HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

2611 SOUTH DEARBORN
SEATTLE, WA 98144

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

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(X5) COMPLETION DATE

F 246 Continued From page 7

Call lights were found out of reach for residents #17, #99, #141 and #52 on the first floor. The nurse assigned to the area stated residents #141 and #52 could use and should have the call lights in reach. Resident #17 and #99 stated they used the call light if within reach if they needed assistance from staff.

At 9:30 am, on the second floor call lights were found out of reach for resident #20, #33 and #89. Resident #33 indicated she did not know where the call light was located. She reported she was able to use the device if within her reach. Although Resident #89, did not respond verbally he looked for the call light when asked and indicated through gestures he was unable to locate it.

F 248 SS=D 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES

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.

This REQUIREMENT is not met as evidenced by:
Based on observations, interviews and record review the facility failed to provide 1 of 3 residents review for activities, an activity program at the highest practicable level which corresponded with the facility's assessments. This failure had the potential to decrease the quality of life for this resident.

F 246

F246 continued
LNs will make call lights checking rounds on their assigned units every day/ every shift to ensure call lights are within the reach of each resident. Day, evening and night LNS will be provided with the daily call lights audit tool that can be utilized. LNS on each unit will report their findings to the resident care manager. The resident care manager will conduct compliance rounds each shift to check the call lights placement and turns in deficiencies to the DON/designee.

Monitoring

The Resident Care Managers will make call lights checking rounds once a week on each unit x3 shifts and inspects call lights placement visually to ensure call lights are within the reach of residents and policy and procedures related to call light are being implemented effectively. Compliance rounds results will be discussed in a monthly CQI to evaluate the effectiveness of the policy and procedure in place.

F 248

10-10-13

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F 248	<p>Continued From page 8 FINDINGS INCLUDE:</p> <p>Resident #203 Resident # 203 was [redacted] years old and admitted to the facility on [redacted]/13 for extensive care needs related to multiple medical diagnoses which impacted his lower extremities mobility and qualified for [redacted] care.</p> <p>On 08/22/13 at 3:09 p.m. the resident stated he could not get out of bed on his own and was unaware of any activities provided by the facility other than the television in his room available for his personal use. The resident stated he would like to take a walk outside.</p> <p>On 08/27/13 a record review of the facility activity assessment form and a questionnaire entitled, "All About Me" revealed the resident has stated he like to take walks with his family in the yard prior to admission. It was noted the residents like pets, computers and watching TV.</p> <p>On 08/29/13 at 09:35 a.m. Staff D, the RCM, stated a wide vary of television channels are provided for this resident to watch. In further discussion about the resident's preferences noted on the activity assessment, Staff D stated the resident enjoyed pets, but the pet volunteer was unable to come to the facility. The resident liked computers so the facility will ask the family to bring in a laptop. The resident liked to visit with his family, so the facility will provide a chair next to his bed for family visitors.</p> <p>Observations on 8/20/13 at 9:00 a.m. revealed a private visiting room available for residents and a computer in the room adjacent to the dining room was used by residents. However the resident</p>	F 248	<p>F248</p> <p>Leon Sullivan Health Care Center has a comprehensive activities program in place. Employees in the activities assess each resident on admission, quarterly, annually and as needed. This department also writes care plans that reflect residents' specific needs and implements accordingly.</p> <p>Corrective actions taken</p> <p>Resident specific</p> <p>Resident #203 is no longer in the facility.</p> <p>Because all residents participating in activities programs are potentially affected by this cited deficiency; under the direction of the Activities Director all activities department employees, social workers and nursing staff have been in-serviced on the importance of helping residents to participate in activities of their choice according to their physical ability and needs. All residents' activities care plans have been reviewed by the Activities Director to ensure activities approaches were based on likes/preferences.</p>	10-10-13
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F 248	Continued From page 9 was never observed there.	F 248	F248 continued In order to address systemic changes; the facility revised the existing assessment tool that can help record one-on-one activities. Actions taken to insure solutions to the cited deficiency are sustained and reoccurrences prevented The Activities Director/designee will assess all residents using existing/amended assessment tool upon admission, quarterly, annually and with significant changes in condition to determine their level of care, needs/preferences and initiates care plans that are specific to residents' needs and preferences.	10-10-13
F 278 SS=D	On 08/29/2012 at 10:06 a.m. Staff F, Activities Director, reviewed the documentation regarding activities program for Resident #203 and stated the resident initial assessment should have been completed upon admission was not until 08/21/2013. Staff F confirmed the resident stated his preference to walk outside with family. Staff F was unable to find documentation of any attempts to coordinate with the social worker activities which involved the family. Staff F stated this should be their practice to document these efforts. Staff F continued to review the documentation for the activities program and determined the resident was not offered activities on 08/16-20 & 22-28/2013. Staff F concluded this resident's activities needs were not met. 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who	F 278	The activities director will also educate the activities department employees on how to address resident's specific needs and evaluate the care plans put in place to determine that the plan of care is being followed specific to activities. Monitoring The Activities Directed/Designee will conduct monthly activity audits to ensure compliance with policy and procedures related to activities are being sustained. The Activities Director will also make weekly rounds and	

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F 278	<p>Continued From page 10</p> <p>willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure the assessments accurately identified the resident conditions for 3 of the 43 residents (#154, #139, and # 204) reviewed during stage II. Failure to accurately identify the resident functional abilities and physical conditions placed the residents at risk of unidentified and unmet care needs.</p> <p>FINDINGS INCLUDE:</p> <p>Resident #154 Resident #154 was admitted to the facility on 01/13 with multiple diagnoses including diabetes and arthritis. Review of the initial MDS assessment, dated 01/27/13, indicated the resident needed limited assistance with most of the activities of daily living (i.e. bed mobility, transfers, locomotion and toileting). The assessment stated the resident need physical assistance from the staff for wheelchair mobility.</p> <p>Review of the subsequent quarterly assessments,</p>	F 278	<p>F248 continued</p> <p>visually inspect while employees are engaged in activities with residents.</p> <p>The Activities Director/Designee will meet with the resident council president and residents' families once a month to discuss activity programs effectiveness. Outcomes will be presented to the monthly CQI meeting for evaluation and recommendations.</p> <p>F278</p> <p>Thorough and Holistic assessment of residents and accurate documentation of findings will help employees initiate care plan that addresses residents' specific needs and expectations. Inaccurate data gathering and coding can potentially impact the quality of care provided. At Leon Sullivan Health Care Center, MDS coordinators are expected to use Different data gathering methods for the MDS Coding purposes. Incidents and grievance logs, and all progress notes from different disciplines or departments should be reviewed before coding is completed.</p>	10-10-13
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F 278	<p>Continued From page 11 dated 04/27/13 and 07/27/13, revealed the staff did not accurately identify the residents fall history. The incident reporting log documented the resident fell on 04/10/13, 04/20/13, and on 06/06/13, but the Minimum Data Set (MDS) dated 07/27/13, did not identify falls.</p> <p>Although the assessment tool directed staff to respond to, "Has the resident had any falls since admission or the prior assessment." Neither of the assessments accurately identified the falls noted in the log. The resident had a Prospective Payment System (PPS) assessment on file, dated 02/06/13, however the falls documented in the log that occurred on 4/10, 4/20/2013, should have been identified on the MDS completed 04/27/13. The subsequent MDS assessment, dated 07/27/13 should have identified the fall that occurred on 06/06/13.</p> <p>Resident # 139 Resident # 139 was admitted to the facility on 08/10/2013 with multiple diagnosis including a [REDACTED] disease. The resident was alert and oriented, able to make his needs known. According to the most recent quarterly Minimum Data Set Assessment, dated 7/30/13, documented the resident needed total and/ or extensive assistance with most activities of daily living (i.e bed mobility, transfers, dressing, grooming, and locomotion.)</p> <p>The resident clinical record noted the resident was being treated pressure ulcer, which was assessment by a wound consultant on 01/16/13. The wound consultant noted the wound documented the Stage IV pressure ulcer was "4.5 cm by 3 cm x 2 cm with undermining from 9-3 with the deepest portion of 6 cm at 12 o'clock."</p>	F 278	<p>278 continued</p> <p>Corrective Action taken for identified issues.</p> <ol style="list-style-type: none"> 1) Resident #203 is no longer in the facility 2) For resident #154, skin assessment was completed, care plan put in place and treatment to open area (R) shin was initiated on 8/26/2013-skin issue is now resolved. Fall risk assessment and care plans were also updated. 3) For resident #139, care plan was revised, new air mattress was provided to prevent pressure ulcer from getting worse. 4) MDS coordinators have been in-serviced on coding accuracy, legal and financial implications of coding errors. 5) Documentation audit team has been formed. This committee will review NACS' Nurses' and other departments' documentation for accuracy and reports its findings to the unit mangers for evaluation. This audit follows MDS calendar. 	10-10-13
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F 278	<p>Continued From page 12</p> <p>The consultant made recommendations concerning treatment and completed a follow up assessment on 01/25/13.</p> <p>Although a MDS was completed 12/08/12, the assessment documented the resident did not have any pressure ulcers. On 8/27/13 At 10:00 a.m., during an interview Staff Y, the MDS coordinator explained that it started off as a reddened area and then opened to a stage III pressure ulcer. When asked why the wound was not documented on the MDS assessment, dated 12/08/13, she commented she just missed it. She agreed the wound should have been noted on the assessment.</p> <p>Not ensuring the assessment accurately identified the stage, size and description of the wound may have contributed to a delay in treatment and healing.</p> <p>Resident # 203 Resident #203 was admitted to the facility on [REDACTED]/2013 with multiple care needs related to a [REDACTED]. The facility completed the comprehensive assessment (MDS) on 08/2013. On 08/22/2013 at 10:08 the resident stated he had cavities and his teeth were sensitive to hot and cold which caused him problems with eating. Record review of the MDS dated 08/20/2013 revealed no abnormal dental conditions existed. In an interview with Staff V, the MDS nurse, on 08/30/13 at 10:45 a.m. she stated the resident was angry, so she read the registered dietician assessment for her information to complete the dental assessment for resident #203. No cavities were noted.</p> <p>Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User 's Manual</p>	F 278	<p>278 continued</p> <p>Because the cited deficiency potentially affected all residents, under the Direction of the staff development coordinator, all LNs, social services employees, Restorative and MDS coordinators will be in-serviced on:</p> <ol style="list-style-type: none"> 1) Data gathering methods. 2) Open communication, information sharing and accuracy of coding. 3) Determining level of care and care planning 4) Skin assessment and documentation 5) Dental services, pressure and non-pressure wounds care. 6) Incident investigation <p>Actions taken to ensure solutions to the cited deficiency are sustained and reoccurrences prevented.</p> <p>The audit committee will create audit tools that can help track documentation and coding errors. This audit tools will be used upon admission, when residents discharge from the facility, during quarterly and annual resident assessment periods and as needed. Completed records audit will be placed in resident care managers and MDS coordinators</p>	10-10-13
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F 278	Continued From page 13 dated July 2010, instructed the nurse to conduct an interview with the resident and complete a visual oral assessment. The assessment also allowed Staff V to document she was unable to examine the resident mouth, but this was not done by facility staff.	F 278	278 continued folders for review and completion. The MDS Coordinators will review all nursing, social services, PT/OT, and consultants' notes, interview NACs, Nurses, families and others before MDS coding to avoid errors. MDS Coordinators will also review incident log during the assessment period. Skin check will be done upon admission by the admission nurse and then every week by LNs on duty. Fall risk assessment will be completed as soon as the resident arrives at the facility and plan of care put in place.	10-10-13
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that care plans reflected the current care needs for two residents of 30 residents (# 117 and #154) reviewed in stage II. Failure to ensure the care plan</p>	F 280	<p>MDS coding to avoid errors. MDS Coordinators will also review incident log during the assessment period. Skin check will be done upon admission by the admission nurse and then every week by LNs on duty. Fall risk assessment will be completed as soon as the resident arrives at the facility and plan of care put in place.</p> <p>Monitoring</p> <p>The Quality Assurance Nurse/designee will monitor the implementation of policy and procedures related to assessment, documentation accuracy, care planning and implementation through reviewing resident's medical records, MDS coding and quality indicators every quarter and as needed to ensure the process is effective. Compliance will be monitored by DON and reviewed in a monthly CQI meeting.</p> <p>F 280</p> <p>It is the policy of Leon Sullivan Health care Center to assess each resident up on admission, change of condition,</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505511	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/30/2013
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F 280	<p>Continued From page 14 accurately identified care needs placed them at risk for unmet care needs</p> <p>Findings include:</p> <p>Resident # 177</p> <p>Resident # 177 was admitted to the facility on [redacted]/13 with multiple diagnoses including a [redacted]. The resident initial treatment plan included a [redacted] a mechanical device used to [redacted]. The initial Minimum Data Set (MDS) assessment noted the resident was alert and oriented and was continent of bowel and bladder. The care plan indicated the resident used a urinal and a bed pan, and was able to alert staff when assistance was needed.</p> <p>On 08/28/13 at 10 am the resident was observed lying in bed, no urinal was observed at the resident's bedside. At 11:45 am the resident was asked about the urinal kept at the bedside. He stated that if he needed to use it he had to turn on his call light to ask for the device. He reported that he was wearing a brief that contained the urine if the staff were not able to answer the call light right away.</p> <p>Review of the clinical record found after 04/26/13, the resident was readmitted to the hospital on five different occasions since the original admission date. The initial assessment, dated [redacted] 13 noted the resident was continent of bowel and bladder. However on 06/09/13, a significant MDS change assessment was completed, it now stated the resident totally incontinent.</p> <p>Review of the resident care guide, a document</p>	F 280	<p>F280 continued quarterly, annually and develop comprehensive care plan that addresses residents' physical, mental, social cultural, and other related needs. The care plans developed in the facility follow the MDS Calendar. Care conferences are coordinated by the social department and attended by the residents, family members, physicians, LNs and other concerned individuals or departments.</p> <p>Corrective Actions for identified issues</p> <p>Resident specific: Resident #177 is continent of B&B per Hospital discharge summary and LNs' documentation, but was coded as incontinent by one of the MDS coordinators. This MDS nurse coded the resident as incontinent based on the NAC's documentation. The resident has been re-assessed for B & B related issues and found to be continent of B & B. He uses bed pan and urinals because of generalized body weakness related to multiple medical issues-not strong enough to go to the bath room or to use bed side commode. Specific care plan that reflects his B & B status has also been initiated. As stated in the citation, this resident had skin issues that had been resolved.</p>		

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(X5) COMPLETION DATE

F 280

Continued From page 14 accurately identified care needs placed them at risk for unmet care needs

Findings include:

Resident # 177

Resident # 177 was admitted to the facility on [redacted] /13 with multiple diagnoses including a [redacted]. The resident initial treatment plan included a [redacted] device used to facilitate [redacted] (.) The initial Minimum Data Set (MDS) assessment noted the resident was alert and oriented and was continent of bowel and bladder. The care plan indicated the resident used a urinal and a bed pan, and was able to alert staff when assistance was needed.

On 08/28/13 at 10 am the resident was observed lying in bed, no urinal was observed at the resident's bedside. At 11:45 am the resident was asked about the urinal kept at the bedside. He stated that if he needed to use it he had to turn on his call light to ask for the device. He reported that he was wearing a brief that contained the urine if the staff were not able to answer the call light right away.

Review of the clinical record found after 04/26/13, the resident was readmitted to the hospital on five different occasions since the original admission date. The initial assessment, dated 05/3/13 noted the resident was continent of bowel and bladder. However on 06/09/13, a significant MDS change assessment was completed, it now stated the resident totally incontinent.

Review of the resident care guide, a document

F 280

F280 continued quarterly, annually and develop comprehensive care plan that addresses residents' physical, mental, social cultural, and other related needs. The care plans developed in the facility follow the MDS Calendar. Care conferences are coordinated by the social department and attended by the residents, family members, physicians, LNs and other concerned individuals or departments.

Corrective Actions for identified issues

Resident specific: Resident #177 is continent of B&B per Hospital discharge summary and LNs' documentation, but was coded as incontinent by one of the MDS coordinators. This MDS nurse coded the resident as incontinent based on the NAC's documentation. The resident has been re-assessed for B & B related issues and found to be incontinent of B & B, uses bed pan and urinals. Specific care plan that reflects his B & B status has also been initiated. As stated in the citation, this resident had skin issues that had been resolved.

Resident #154 has intermittent abrasions that come and go.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505511	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/30/2013
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F 280	<p>Continued From page 15</p> <p>used to communicate care directives to the nursing assistants, directed staff keep a urinal at the bedside and noted the resident used a bedpan. The care plan, dated 4/26/13, documented the resident was continent of bowel and bladder and indicated the resident needed assistance from staff. However this did not meet his current care need..</p> <p>On 8/28/13 at 12:55 p.m., the Licensed Nurse, Staff # L, was interviewed about the resident toileting plan. She reported the resident was able to turn on the call light and ask for assistance to use the toilet in the bathroom.</p> <p>On 8/28/13 at 1:00 p.m., during an interview, Staff K, (the Nursing Assistant assigned to the resident) reported the resident did not use the toilet in the bathroom. She reported the resident wore incontinent briefs and was on a check and change program.</p> <p>The Resident Care Manager, Staff C was also interviewed on 1:10 p.m., she stated the resident was alert and reported the resident was able to walk to the bathroom to use the toilet. When asked about the care guide directives the RCM reported, that on initial admission the devices were used because the resident was not able to walk. She stated that the resident had improved and was currently able to use the bathroom. The care plan did not reflect his current care needs.</p> <p>Not ensuring the care plan accurately identified the resident's need for assistance to use the bathroom, and indicated he had improved mobility and could walk to the bathroom placed him at risk for unmet care needs.</p>	F 280	<p>F280 continued</p> <p>An open area was discovered on her (R) leg (shin) on 8/26/2013.</p> <p>LNS, NACs and MDS Coordinators have been in-serviced on accurate and coordinated documentation and coding</p> <p>Resident #154 has been assessed for skin related issues, care plan initiated and treatment orders for the (R) leg was obtained on 8/26/2013- skin issue is resolved now.</p> <p>Because all residents are potentially affected by this citation, under the direction of DON, all nursing staff will be in-serviced on the importance of accurate and timely documentation, coordinated interdepartmental communication, legal and financial implications of coding errors, weekly skin checks, Catheter related policies and procedures (residents that are admitted to the facility without catheter should not be catheterized unless justified).</p> <p>Actions taken to ensure solutions to the cited deficiency are sustained and reoccurrences prevented</p>	10-10-13
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F 280	<p>Continued From page 16 Resident # 154</p> <p>Resident # 154 was admitted to the facility on [REDACTED] 13 with multiple diagnosis including diabetes and arthritis. Review of the initial MDS assessment, dated 1/27/13, documented the resident needed limited assistance with most of the activities of daily living (i.e. bed mobility, transfers, locomotion and toileting.) The assessment also noted the resident had no skin impairments, which could be skin ulcers, skin tears and or rashes. Review of the most recent MDS quarterly assessment, dated 7/27/13 provided the same information.</p> <p>On 08/22/13 the resident was interviewed at 9:30 am, during the interview the resident pulled up her right pant leg and displayed an abrasion which appeared to be bruised and scabbed. The abrasion/ bruised area appeared to be approximately 5 to 6 inches long. During an additional observation on 08/26/13 at 9:40 am the resident was observed in a supine position on her bed. The lower extremities were visible, and in addition to the abrasion on the right leg the resident was noted to have an open area on the left leg as well. When asked how the injuries observed occurred the resident commented " I just run into things. "</p> <p>There was no evidence the care plan identified the wounds or any treatment provided for them. On 08/26/13 at 1:30 p.m., Staff C and L, reported the abrasions on the resident lowers legs had been present for the past two weeks. When asked what caused the wounds the RCM, was not certain how the abrasion/bruises and/r scabs occurred. Not ensuring the care plan identified the wounds, the size, location and a description,</p>	F 280	<p>F280 continued</p> <p>Documentation accuracy and MDS Coding are implemented effectively and sustained. Each Department will have communication folders for interdepartmental communication. Resident care mangers will be responsible for checking the communication folders daily and relaying messages left in the folders to other employees in the department. Restorative department coordinator will assess all new admits for B & B retraining program within 7days of admission and sets up a retraining program per policy. The admission Nurse will complete initial skin assessment up on admission. On duty LNs will check skin every week on shower days and as needed.</p> <p>Monitoring</p> <p>The Quality Assurance Nurse or Designee will review all new admits records within the first 21 days to ensure assessments and care plans by all departments and coding are complete and accurate. The quality Assurance Nurse/designee will also review the communication folders on each department once a week to ensure interdepartmental</p>	10-10-13
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F 280	Continued From page 17 and indicated what treatment was provided left the resident at risk for unmet care needs.	F 280	F280 continued communication files are utilized as intended. Restorative or treatment nurse will make skin round every week with IDT and visually monitor residents' skin, pressure and non-pressure wounds to ensure effectiveness of skin care.	
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.	F 285	Compliance will be reviewed in a monthly CQI. F 285 Leon Sullivan Health care Center understands that the goal of Preadmission screening and resident review (PASRR) is to help Long-Term Care Facilities in providing necessary and quality services to each resident according to their identified physical, mental, and psychosocial and other related needs. Per Federally mandated PASRR guidelines, the facility ensures that all prospective admits have a level I screening done prior to admission with no exception. Residents positive for level I will be referred for level II evaluation per guidelines and procedures. Because all residents with mental issues are potentially affected by the	10-10-13

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F 285	<p>Continued From page 18</p> <p>For purposes of this section:</p> <p>(i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1).</p> <p>(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interviews, the facility failed to ensure Pre-Admission Screening and Resident Review (PASRR) assessments were accurately completed for 1 of 3 Resident's (#158) sample residents of 6 residents who were assessed for a Level II PASRR. Failure to ensure PASRR assessments were completed accurately placed resident at risk for receiving less than necessary services for mental health needs.</p> <p>Resident #158 was admitted to the facility on [redacted] 2012 for multiple care needs. Record review revealed the diagnosis of developmental disabilities (DD) was noted on the physician's history and physical completed on 12/03/2012. Review of the PASRR completed by the facility Social Worker, Staff U, and signed by the physician marked a negative answer to the three questions regarding DD Indicators.</p> <p>On 8/27/2013 at 3:45p.m. Staff U stated he interviewed the resident and determined he was cognitively intact and did not appear to have manifestations of DD. Staff U also stated he did not review the history and physical before the interview with the resident. Staff confirmed the PASRR did not recognize the DD diagnosis and</p>	F 285	<p>F285 continued</p> <p>cited deficiency (F 285), for resident #158 and all, under the direction of the Social Services Director, all LNs in general and social services employees in particular will be in-serviced on:</p> <ol style="list-style-type: none"> 1. Federal guidelines related to PASARR. 2. The importance of assessing residents with mental illness, mental retardation, or related diagnosis or conditions and referring them to appropriate mental health professionals for further evaluation. 3. How to improve assessment skills that might help determine if this facility is appropriate for residents with diagnosis of mental illness or retardation (Resident #158). 4. Potential negative outcome of disconnections between residents' Diagnosis and our in-house assessment and documentation such as with resident #158. <p>Actions taken to ensure solutions to the cited deficiency are sustained and reoccurrences prevented.</p> <p>The Social Services Director will review medical records of all prospective</p>	10-10-13

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F 285	Continued From page 19 special services were not provided as a result of the inaccurate assessment.	F 285	F285 continued admits with mental illness and behavioral issues prior to admission. The social services director and admission department will inform hospitals' discharge planners that our facility will not accept residents that haven't been assessed for level I PASRR and others with serious mental illness/ DD. The Social workers will assess each resident with mental illness accurately to determine level and appropriateness of care at our facility. Staff U and other Social workers will be educated on how to conduct interview, utilize assessment tools and detect level II PASRR indicators to prevent the cited deficiency from reoccurring and ensure residents receive appropriate care.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure staff monitored wounds for one of three Stage II residents (# 154), who had non-pressure related skin conditions. Failure to ensure the wounds were monitored placed the resident at risk for unmet care needs and poor wound healing. The facility policy for the treatment of non-pressure related skin conditions, noted that if any skin impairments were identified, the staff should note the size, location and description of the wound. It also stated that weekly documentation of the wound would be entered into the resident clinical record. Resident # 154 Resident # 154 was admitted to the facility on	F 309	Monitoring Social Services Director will review all the new admits' medical records/history within 7 days and conduct interviews to ensure policy and procedures related to assessing Residents for level I & II are being implemented effectively. The social services director will audit charts every quarter to make sure all residents have level I PASRR assessment done and those with level II PASRR get appropriate care. Compliance is reviewed in a monthly psychoactive medication review committee meetings and further evaluated for effectiveness in a monthly CQI committee meetings.	

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F 285	Continued From page 19 special services were not provided as a result of the inaccurate assessment.	F 285	F285 continued admits with mental illness and behavioral issues prior to admission.	
F 309 SS=D	On 08/30/2013 at 9:00 a.m. Staff U stated he was unable to produce documentation which identified when Resident #158 was originally diagnosed to be developmentally delayed. 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure staff monitored wounds for one of three Stage II residents (# 154), who had non-pressure related skin conditions. Failure to ensure the wounds were monitored placed the resident at risk for unmet care needs and poor wound healing. The facility policy for the treatment of non-pressure related skin conditions, noted that if any skin impairments were identified, the staff should note the size, location and description of the wound. It also stated that weekly documentation of the wound would be entered into the resident clinical record. Resident # 154 Resident # 154 was admitted to the facility on	F 309	The social services director and admission department will inform hospitals' discharge planners that our facility will not accept residents that haven't been assessed for level I PASRR and others with serious mental illness/ DD. The Social workers will assess each resident with mental illness accurately to determine level and appropriateness of care at our facility. Staff U and other Social workers will be educated on how to conduct interview, utilize assessment tools and detect level II PASRR indicators to prevent the cited deficiency from reoccurring and ensure residents receive appropriate care. Monitoring Social Services Director will review all the new admits' medical records/history within 7 days and conduct interviews to ensure policy and procedures related to assessing Residents for level I & II are being implemented effectively. The social services director will audit charts every quarter to make sure all residents have level I PASRR assessment done and those with lever II PASRR get appropriate care. Compliance is reviewed in a monthly weekly psychoactive medication	10-10-13

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F 309	<p>Continued From page 20</p> <p>█/13 with multiple diagnosis including diabetes and arthritis. Review of the initial Minimum Data Set (MDS) assessment, dated 1/27/13, indicated the resident needed limited assistance with most of the activities of daily living (i.e. bed mobility, transfers, locomotion and toileting.) The assessment stated the resident need physical assistance from the staff to move from one location in the facility to another using a wheelchair. The assessment also noted the resident had no skin impairments, which are described as ulcers, skin tears and /or rashes. The most recent MDS documented the same information.</p> <p>On 8/22/13 at 9:30 am, the resident was interviewed. During the interview, when asked about pain the resident pulled up her right pant leg and displayed an abrasion which appeared bruised and scabbed. The area extended from the top of the shin to the mid shin, and appeared to be approximately 5 to 6 inches long. The record noted that no skin impairments were observed during the past two months, the last skin check documented 8/20/13, simply noted the resident's skin was intact.</p> <p>On 08/26/13 at 9:40 a.m., during an additional observation both lower extremities were visible. In addition to the abrasion on the right leg the resident was noted to have an open area on the left leg as well. When asked how the injuries observed occurred the resident commented " I just run into things. "</p> <p>On 8/26/13 at 9:45 a.m., Staff L, the Licensed Nurse responsible for the resident's care was interviewed in regards to resident's care needs.</p>	F 309	<p>F285 continued review and monthly CQI. Psychoactive medication review consist of Physician, Social Services, Nursing and Mental Health Professional.</p> <p style="text-align: center;">F309</p> <p>Prevention of skin breakdown is the top priory at Leon Sullivan Health Care Center. Skin assessment is completed up on admission and findings are documented. Preventative measures such as turning/repositioning residents, applying barriers creams, and providing pressure relieving assistive devices are practiced daily to prevent the risk of skin breakdown. Those identified at risk for skin breakdown are closely monitored by IDT. Skin check is done on weekly basis and documented in MAR .Every unit has two wound assessment folders- one for pressure ulcers and one for non-pressure ulcers. Any change in skin integrity is documented and care planned for immediately.</p> <p>Actions taken</p> <p>Resident specific: For resident #154, skin assessment was completed; treatment order for open area on (R) leg was obtained and initiated on</p>	10-10-13
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F 309	Continued From page 21 She stated the resident should have support stockings in place and that she had reminded the staff to assist the resident with them. She then provided treatment records for the past three months. The record noted that no skin impairments were observed during the past two months, the last skin check, documented 08/20/13, simply noted the resident's skin was intact. On 08/26/13, Staff C, the Resident Care Manager was interviewed about the facilities process for monitoring wounds. She stated that all wounds should be monitored and tracked by the nurse on a form the facility developed. Although additional review of the progress notes was completed there was no mention of any wounds on the lower extremities until after 8/26/13. Although the entry in the record clearly noted the resident had an open area on the right leg, there was no mention in the entry of the scabbed area on the left leg.	F 309	F309 continued 8/26/2013. Skin issue is resolved- no open area. All residents are potentially affected by the cited deficiency. For resident #154 and other residents, under the direction of DON, all nursing staff will be in-serviced on skin assessment protocol and preventative measures to reduce skin breakdown. Ways to improve communication between MDS coordinators and nursing to minimize coding errors will also be discussed during the in-service education. Actions taken to ensure solutions to the cited deficiency are sustained and reoccurrence prevented.	10-10-13	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER 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	F 315	The NACs will report skin condition to LNs on duty every day and every shift. The LNs will assess the resident if the NACs reports indicate actual or potential skin issues. LNs' findings will be documented and reported to resident care managers. The resident care manager/designee will reassess the resident, notify the physician and obtain treatment as needed. Residents' skin will be visually monitored by the NACs during day, evening and night shifts. Any change noted in residents' skin will be		

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F 315	<p>Continued From page 22 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 take measures to attempt to restore normal bladder function for one of three residents with incontinence. This placed the resident at risk for prolonged abnormal bladder fuction.</p> <p>Findings include: Resident # 177</p> <p>Resident # 177 was admitted to the facility on [REDACTED]/13, with multiple diagnoses including a [REDACTED]. The resident's initial Minimum Data Set (MDS) assessment, dated 2/26/13, indicated the resident was alert and oriented and continent of bowel and bladder. Since the original admission date the resident was hospitalized four times with complications associated with multiple diagnoses. The next MDS assessment, dated 06/09/13, noted the resident had a significant change in condition and declined.</p> <p>The care area summary, dated 6/12/13, noted the resident experienced a significant change in condition. Stated he was " bed bound " ... " unable to stand, transfer or ambulate without 2 person extensive assist ... "</p> <p>The care plan, dated 05/06/13, indicated the resident needed extensive assistance with toileting. The care plan goal indicated the</p>	F 315	<p>F309 continued immediately reported to the LNs on duty. Weekly skin check schedule will be re-enforced. IDT will make weekly skin/wound rounds to ensure the process is working effectively.</p> <p>Monitoring</p> <p>The DON will review weekly skin check reports, pressure and non-pressure wound folders every week. DON will also meet with wound/treatment nurse every week and discuss skin related issues and effectiveness of preventative measures in place. DON will make skin/wound rounds with IDT every week and visually monitor wound care and skin assessments. DON will review TAR and Care plans every month to ensure policy and procedures related to skin care are implemented.</p> <p>Compliance will further be reviewed in monthly CQI meetings. F315</p> <p>Restorative department of the facility assesses all residents for:</p> <p>B & B retraining as needed. The main goal of this assessment is to identify changes in physical function due to illness and help residents restore their normal physical functions prior to</p>	10-10-13

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505511	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/30/2013
NAME OF PROVIDER OR SUPPLIER LEON SULLIVAN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2611 SOUTH DEARBORN SEATTLE, WA 98144		
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F 315	Continued From page 23 resident would be able to void using a urinal with the assistance of staff. The care plan indicated the resident used a urinal and a bed pan, and was able to alert staff when assistance was needed. The facility had not implemented measures to restore this function of using the urinal independently. On 08/28/13, at 10 am and 11:45 am multiple observations of the resident in the room were made. A urinal was not observed at the resident's bed side. At 11:45 the resident was asked if the urinal was kept at his bed side, he stated no I have to call the staff and request it. He then stated he was wearing a brief and stated the "brief" would contain the urine if the staff were not able to answer the call light right away. On 8/28/13 at 12:55 p.m., the Licensed Nurse, Staff # L, was interviewed about the resident's toileting plan. Staff L, reported the resident was able to turn on the call light and ask for assistance to use the toilet in the bathroom. She stated the resident's condition had improved and stated the current plan was for the resident to walk to the bathroom.	F 315	F315 continued illness or maintain current physical functions. Decline in physical function is unacceptable unless determined unavoidable. Corrective Actions taken B & B functional status of resident #177 has been very confusing and controversial because of discrepancies in care providers' documentation and MDS coding. He has been re-assessed for B & B retraining program and the trial program will be initiated within a week. NACs, LNs and MDS coordinators have been in-serviced on the importance of B & B retraining, consistency of documentation and care plans that reflect specific needs of individual residents.	10-10-13	
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and	F 319	Because all residents with similar issues are affected by the cited deficiency, under the direction of DON, for resident #177 and all other residents, all nursing staff and MDS coordinators will be in-serviced on: 1. Thorough assessment, accurate and consistent		

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F 319	<p>Continued From page 24 services to correct the assessed problem.</p> <p>This REQUIREMENT is not met as evidenced by: F 319</p> <p>Based on observation, interview and record review the facility failed to ensure for one of 46 resident's reviewed in Stage II, resident behaviors' were monitored and ensure a physician order for a mental health consult was coordinated by the facility staff, placed the resident at risk for unmet and unidentified care needs.</p> <p>Findings include:</p> <p>Resident #16 was admitted to the facility [REDACTED]/23 with multiple diagnoses including depression and dementia. The Initial Minimum Data Set (MDS) assessment, dated 2/26/13, indicated the resident had mildly impaired cognition. The only issue with mood reported by Resident #16 during the interview was a "lack of energy and being tired." The resident reported this was an issue that occurred 1 to 3 days during the 7 day assessment period. The behavioral section indicated the resident displayed behaviors, directed towards self, had no impact on care and/or did not increase the risk of injury for others.</p> <p>The next quarterly MDS assessment, dated 6/5/13, noted a significant decline in the resident cognitive abilities. The staff documented the resident did not respond to the interview questions concerning mood. The behavioral section of the assessment noted the resident displayed behaviors directed towards others,</p>	F 319	<p>F315 continued documentation or coding and care planning in general for residents with B & B issues in particular.</p> <ol style="list-style-type: none"> The importance of B & B retraining and helping resident re-gains functional independence. Types of incontinence and possible causes The importance of making assistive devices accessible to residents. <p>Actions taken to ensure solutions to the cited deficiency are sustained and reoccurrence prevented</p> <p>Restorative nurse will assess all new admits for B & B retraining program within 7 day of admission and initiates specific plan of care that can help resident regain normal B & B function. Nursing will assess residents thoroughly to determine level of care needed and initiates plan of care that reflects individual resident's specific needs. MDS coordinators will gather data that reflect resident's condition and document accurately to minimize or avoid confusion and misrepresentation of facts. New B&B assessment tools, policy and procedures will be introduced.</p>	

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F 319	<p>Continued From page 25</p> <p>impacted the delivery of care, disrupted the environment, interfered with the residents' activities and social interactions with others, and placed others at risk for injury. The assessment also indicated the resident rejected care. There was no evidence these behaviors had been monitored by facility staff.</p> <p>Despite all the changes noted between the initial MDS and quarterly assessment, the staff documented there were no changes in the resident behaviors.</p> <p>Review of the clinical record found that at the time of admission the only psychotropic medication prescribed was an antidepressant and had significant issues with pain that was treated with narcotic medications.</p> <p>Review of the physician orders found that on 3/15/13, the resident was placed on an [redacted] medication ([redacted]) and an additional [redacted]. The [redacted] medication was administered, according to the physician orders for " Dementia with [redacted]. " An additional physician order indicating the resident needed a [redacted] evaluation was found in the written physician orders, dated 3/27/12. However there was no evidence found in the resident to indicate a [redacted] provider evaluated the resident.</p> <p>Not ensuring the resident behaviors were monitored left the facility without needed information to assess the effectiveness of the interventions, which included the administration of [redacted] medications. Not ensuring the order for mental health evaluation and treatment was facilitated by the facility staff increased the risk</p>	F 319	<p>F315 continued</p> <p>Monitoring</p> <p>DON will audit records of all residents with B&B program once a month to ensure the B&B retraining program is implemented effectively and sustained. DON will meet weekly with restorative nurse and discuss progress in B&B retraining program. DON will also review a sample of nurses and MDS coordinators assessment and documentation to determine accuracy of documentation and coding on a monthly and as needed basis. Nursing rounds tools will be utilized for this purpose.</p> <p>Compliance will further be reviewed in monthly CQI meetings.</p> <p>F319</p> <p>Residents with behavioral issues should be assessed and closely monitored for their own safety and others. Leon Sullivan Health care Center's social service workers coordinate and care plan for residents with mental issues receiving antipsychotic medications. Effects and side effects of each medication are monitored by nursing staff and discussed in the nursing social</p>	10-10-13	

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F 319	Continued From page 26 the resident who displayed symptoms of adjustment difficulty as risk for further deterioration of their r [redacted] health status.	F 319	F319 continued	10-10-13
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure food was prepared, and distributed under sanitary conditions. Failure to ensure that dishware was washed and stored properly, ensure equipment was maintained under sanitary conditions and doors to the kitchen were utilized as effective barrier for insects increased the risk of food borne illness. NOT ENSURING DISHES AND DISHWARE WAS WASHED AND STORED PROPERLY: During the initial tour of the dietary department on 8/20/13 at 8:45 a.m., two dietary staff were observed working in the dish washing area. The dishes, dinner plates and insulated plate covers, were being stacked after washing had visible	F 371	services and psychoactive medication review meetings. Target behaviors such as refusal of care, yelling, cursing and any disruptive behaviors are closely monitored and documented in MAR and progress note section of resident's medical records. If these behaviors persist, the resident is referred to mental health professionals for further evaluation, possible medication adjustment and recommendations. Action Taken Resident specific: Resident #16 is no longer in the facility. This citation potentially affected all residents with mental/behavioral needs. Under the direction of DON; all nursing staff, social service workers and MDS coordinators will be in-serviced on: 1. How to assess resident with mental and behavioral issues and make referral to the appropriate departments. (Mental health professionals)	

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F 371	<p>Continued From page 27 water on the surfaces.</p> <p>On 8/23/13 at 1:30 pm, three dietary staff was working in the dish room. The dishes, dinner plates and insulated covers were observed with water pooling on the surfaces when stacked after being washed.</p> <p>On 8/27/13, during observation of meal service, both the plates and insulated plate cover were observed with pooled water. During the observation when staff FF, was observed placing the plate covers over the plated food, water was observed to run on the food. In addition Staff GG, who was preparing the plates was observed to use dinner plates with water pooled on the eating surface.</p> <p>Not ensuring the dishware was properly dried could allow for the growth of germs and bacteria in the residual water.</p> <p>Failure to clean and sanitize equipment after use and ensure surfaces were sanitized after use during food production.</p> <p>On 8/20/13 at 8:45 a.m., the juice machine in the cooks prep area was soiled with juice spills and splashes on the rack. The juice gun was soiled and sticky on the outside and smelled like sour juice. A swarm of fruit flies was observed swarming the equipment.</p> <p>On 8/23/13 at 2:55 p.m., a check of the sanitizer buckets observed in the kitchen found three bucket of sanitizer were available. Two of the three buckets tested did not contain a sufficient concentration of sanitizer to effectively sanitize surfaces cleaned. During a follow up interview</p>	F 371	<p>F319 continued</p> <ol style="list-style-type: none"> Antipsychotic, depressants and other medications review and adjustment process. (GDR) Possible negative outcome of failure to assess residents with behavioral issues. How to minimize coding errors by coordinating nursing assessments with MDS process (Calendar). How to improve interdepartmental communication to enhance consistency in collecting and sharing information. How to identify change in residents' condition and take appropriate actions to prevent possible decline in condition. <p>Actions taken to ensure solutions to the cited deficiency are sustained and reoccurrences prevented.</p> <p>DON/Social Services Director will review medical records of all current residents in the facility with mental/psychosocial issues and adjustment difficulties to determine the appropriateness of care. The Social Services staff will assess each resident with mental illnesses accurately to determine level</p>	(0-10-13)
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A. BUILDING _____

B. WING _____

08/30/2013

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LEON SULLIVAN HEALTH CARE CENTER

2611 SOUTH DEARBORN
SEATTLE, WA 98144

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F 371	<p>Continued From page 28</p> <p>the on 8/27/13, at 3:50 pm, Staff E, reported five buckets of sanitizer were usually located in the food service department.</p> <p>FAILURE TO ENSURE THE DOORS WERE USED TO EFFECTIVELY MAINTAIN A BARRIER FOR GERMS, INSECTS AND UNDESIRABLE VERMIN:</p> <p>The exterior door in the kitchen was propped open and a screen door was closed to maintain a barrier, however there was a gap around the door that was approximately 1/4 of inch or more, which would allow insects access to the kitchen area, the door was in close proximity to the juice dispenser. In addition the interior door to the kitchen was propped open.</p> <p>During additional observations through out the survey the interior kitchen's door, into the shared hallway was propped open. The laundry room door, also located in the same hallway, was frequently open as well. (Observed on 8/21, 8/22, 8/23, 8/26.)</p>	F 371	<p>F319 continued</p> <p>and appropriateness of care at our facility.</p> <p>Monitoring</p> <p>DON/Social Services Director will conduct a quarterly review of all current residents' medical history to ensure policy and procedures related to assessing residents with mental/social issues are appropriately implemented.</p> <p>Medical records review will include reviewing nursing assessments, behavior monitoring documentation, social service, physician and consultants notes.</p> <p>Compliance is reviewed in monthly psychoactive medication review (GDR) and monthly CQI.</p>	
F 412 SS=D	<p>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS</p> <p>The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p>	F 412	<p>F371 Measure taken</p> <ol style="list-style-type: none"> All dietary staff have been in serviced on the proper dishwashing procedure of wearing disposable gloves whenever handling contaminated items. Then they are to remove their gloves and thoroughly wash their hands in a dedicated hand washing sink before 	

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F 412	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on interview, observations and record review it was determined the facility failed to provide routine dental services to 1 of 3 residents of the 40 sampled residents. Failure to provide these services resulted in delayed care and decreased quality of life. RESIDENT #158 Resident #158 was admitted to the facility on [REDACTED]/2012 for extensive assistance with activities of daily living related to multiple medical diagnosis and developmental disability. An observation on 8/22/2013, at 11:23 a.m. revealed Resident # 158 had no upper teeth in the front of his mouth. The resident explained he broke his upper denture at his prior community residence and he was told he would get dentures soon. Review of care plan initiated upon admittance noted resident reported upper denture broke and was placed on a mechanical soft diet to ease chewing. On 05/07/2013, the dietician noted the resident preferred a regular diet to a mechanical soft. The resident told the dietician he cuts up his food to compensate for chewing. On 07/02/2013, the practitioner from Smile Seattle Dentures performed an oral exam on Resident #158 and recommended new dentures for the upper teeth.	F 412	F371 continued ever entering the clean side of the dish area to unload any sanitized dishes, utensils, etc. 2. All dietary staff have been in-serviced on the proper storing practices of all dishes to assure they are stored without moisture to prevent possible bacterial growth. Specific drying racks haven been purchased from manufacturer of Dome Covers to assure faster drying times. 3. The juice gun has been added to the daily cleaning schedule and includes removal of tray and nozzle protective cover and will be sanitized in the dish machine. 4. All dietary staff have been in serviced regarding proper mixing ratio for sanitizer buckets and proper placement of said buckets. 5. The screen door to the kitchen has had 1" weather stripping added to both sides of it to ensure no gap exists and insects may not enter.	10-10-13
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F 412	Continued From page 30 On 08/30/2013, Staff Q, social services, stated she was unable to find a referral for resident to be fitted for dentures.	F 412	F371 continued	10/10/13	
F 431 SS=E	A fax received on 09/03/2013, included the DSHS form for Denture/Partial Appliance Request for Skilled Nursing Facility Client. This was completed and signed by the physician though the date was not legible. The form also inaccurately noted this was the client's first set of dentures/partial and did not answer the question regarding previous appliances. 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked,	F 431	Measures taken to ensure solutions are sustained: Daily visual, as well as weekly written sanitation and safety rounds will be completed by Operations Dir./food service Dir. and our consulting Dietician to ensure these procedures are being strictly adhered to by the foodservice staff to ensure the utmost safety for the residents and staff. Monitoring: The Operations Director/FSM will monitor this process thru visual and written review with the registered Dietician and the Administrator to ensure compliance. This system will also be reviewed by our Quality Assurance program team monthly to ensure this process is working effectively,		

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F 431	<p>Continued From page 31</p> <p>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 and interview, it was determined the facility failed to ensure medications stored in the 100 hall, north and south treatment carts were consistently locked when unattended by licensed nurses. In addition, vials of medications were not dated when opened, there was no access to emergency insulin vials, and expired medications were not discarded timely placed residents at risk for potential harm.</p> <p>Findings include:</p> <p>UNLOCKED TREATMENT STORAGE CARTS</p> <p>On 08/27/13 at 3:08 pm a treatment cart was observed unlocked in the 100 south hall next to resident room 140. The cart was observed to contain numerous prescription creams, ointments and liquids. Between 3:08 pm and 3:24 pm two residents passed by the cart on the way to their rooms. At 3:24 pm Staff K, a Registered Nurse, locked the treatment cart.</p> <p>During an interview on 08/27/13 at 3:33 pm with Staff C, Resident Care Manager, she stated "it is</p>	F 431	<p>F412</p> <p>Leon Sullivan Health Care Center usually provides onsite dental services and refers residents to an emergency dental clinic as needed. Unit clerks make dental appointments for non-emergency dental issues. Resident #158 will be examined and treated by mobile or on site dentist.</p> <p>Prevention of decline in condition while waiting for dentures.</p> <ol style="list-style-type: none"> 1. Staff will provide oral hygiene every shift to prevent food from getting trapped in the space left by the denture-food. May attract bacteria leading to infection. 2. Staff will assess the resident for possible pain or discomfort related to missing teeth and offer pain medications as needed 3. Dietician will assess resident and adjust his diets as needed so that he won't lose weight. 4. Staff will monitor for change in speech pattern related to not having dentures in place. 5. Staff will provide the resident with fruits and vegetables supplements. 6. Facility will transfer the resident to E.R. for dental services as needed. 	
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F 431	<p>Continued From page 31</p> <p>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 and interview, it was determined the facility failed to ensure medications stored in the 100 hall, north and south treatment carts were consistently locked when unattended by licensed nurses. In addition, vials of medications were not dated when opened, there was no access to emergency insulin vials, and expired medications were not discarded timely placed residents at risk for potential harm.</p> <p>Findings include:</p> <p>UNLOCKED TREATMENT STORAGE CARTS</p> <p>On 08/27/13 at 3:08 pm a treatment cart was observed unlocked in the 100 south hall next to resident room 140. The cart was observed to contain numerous prescription creams, ointments and liquids. Between 3:08 pm and 3:24 pm two residents passed by the cart on the way to their rooms. At 3:24 pm Staff K, a Registered Nurse, locked the treatment cart.</p> <p>During an interview on 08/27/13 at 3:33 pm with Staff C, Resident Care Manager, she stated "it is</p>	F 431	<p>F412</p> <p>Leon Sullivan Health Care Center usually provides onsite dental services and refers residents to an emergency dental clinic as needed. Unit clerks make dental appointments for non-emergency dental issues. Resident #158 will be examined and treated by mobile or on site dentist.</p> <p>Action taken to ensure solutions to cited deficiency are sustained and recurrences prevented</p> <p>Because all residents are potentially affected by this cited deficiency, under the direction of DON, all LNs and unit clerks will be in-serviced on the importance of providing residents with emergency dental care as required by the State and Federal Laws. The impact of un-healthy teeth on quality of life will also be discussed during the in-service education.</p> <p>All current residents with similar dental issues will be identified by the Dietician and nursing staff and referred to emergency dental services.</p> <p>Dental referral book on all floors will be reviewed by the RCM to ensure no</p>	10-10-13

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FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505511	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/30/2013
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F 431	Continued From page 32 our habit to lock the drawers on the treatment and medication carts." The carts should be kept locked. On 08/28/13 at 9:30 am an unsecured treatment cart on 100 hall south was observed outside resident room #140. The cart was observed to contain numerous prescription creams, ointments and liquids. Staff M, a Licensed Practical Nurse, came and locked the treatment cart. She said "I left it open again." On 08/30/13 at 11:44 am an unsecured treatment cart on 100 hall north was observed. The cart was observed to contain numerous prescription creams, ointments and liquids. Staff N was notified of the unlocked treatment cart. He was observed promptly locking the cart after being notified.	F 431	7. Fee for dental services for this resident has been approved by DSHS as of 10/10/2013. Scott, Andrew, DDS, will be in the facility on 10/15/2013 to take dental impression for new dentures. This on site dental service contract signed between the dentist and the facility will speed up the process of providing emergency dental services at the facility in the future. Action taken to ensure solutions to cited deficiency are sustained and recurrences prevented Because all residents are potentially affected by this cited deficiency, under the direction of DON, all LNs and unit clerks will be in-serviced on the importance of providing residents with emergency dental care as required by the State and Federal Laws. The impact of un-healthy teeth on quality of life will also be discussed during the in-service education. All current residents with similar dental issues will be identified by the Dietician and nursing staff and referred to emergency dental services. Dental referral book on all floors will be reviewed by the RCM to ensure no	
F 441 SS=E	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.	F 441		

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F 441 SS=E	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.	F 441	The Staff Development Coordinator/Designee Nurse will perform quarterly dental orders review on a sample basis to determine systems are functioning according to facility policy and procedures. Findings will be reported to the DON. The DON will meet with the Dentist once a month and as needed to discuss issues related to emergency dental care. Compliance will be monitored by DON and reviewed in monthly CQI meetings.		

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F 441	<p>Continued From page 33</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens 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 observations, interviews and record review it was determined the facility failed to have a system in place to ensure infection control practices were implemented in the kitchen, dining room, incontinence care, dressing change and linen handling. This failure had the potential to compromise the resident's ability to maintain or reach his or her highest practicable level of well being.</p> <p>INFECTION CONTROL PROGRAM On 08/29/2013 at 2:57 p.m. Staff G, the infection control nurse, was unable to analyze the logs she had compiled to determine if the urinary tract infections trended on an decrease or increase. Staff G demonstrated incomplete infection control</p>	F 441	<p>F412 continued treatment orders have been left un-executed.</p> <p>The facility has a contract with a Dentist to provide onsite dental care who will be called when needed.</p> <p>Monitoring</p> <p>RCMs will review the dental referral book daily and follow up on any uncompleted dental orders as needed.</p> <p>The DON will require Unit Clerks to complete monthly reviews on pending emergency dental care to ensure residents receive emergency dental care.</p> <p>The Staff Development Coordinator will perform quarterly dental orders review on a sample basis to determine systems are functioning according to facility policy and procedures. Findings will be reported to the DON.</p> <p>The DON will meet with the Dentist once a month and as needed to discuss issues related to emergency dental care. Compliance will be monitored by DON and reviewed in monthly CQI meetings.</p>	

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F 441	Continued From page 34 data tracking and was unable to demonstrate how the information was used to prevent transmission of infections in the facility. KITCHEN On 8/23/13 at 2:55 pm a Dietary Aide, Staff DD was observed scraping soiled pot and pans in a three compartment sink. The staff then moved to the clean side of the sink area and began stacking clean dishes on racks in the area. On 8/28/13 at 8:50 a.m., Staff DD was again scraping a pan of food residue; the staff rinsed his hands under the faucet in pot and pan sink, without using soap or friction. Staff DD then moved to the cart containing the coffee dispensers and wiped the surface of the cart and rearranged the dispensers. On 8/20 at 8:45 a.m., Staff EE, a Diet Aide was observed loading dishes into the dish machine wearing yellow dish washing gloves. She then removed the yellow gloves, and was wearing clear plastic gloves under the soiled ones removed. The staff then grabbed a clip board in the area and documented water temperatures, without washing her hand or removing the clear plastic gloves. She then returned to work on the soiled side of the dish machine. Staff EE, was observed on 8/23/12 at 1:30 p.m., to again pick up the same clip board and document temperatures. At the time she was wearing clear plastic gloves and stacking clean dishes after being washed. After noting the dishwashing temperature Staff EE returned to the dish area, without removing the gloves and washing hands.	F 441	F431 continued The importance of labeling and monitoring expiration date will also be discussed during this in-service education. Monitoring Using existing audit tool, under the direction of the DON, the Quality Assurance Nurse/SDC will conduct quarterly audits of medication carts, treatment carts and medication rooms to ensure that policy and procedures related to medication storage, labeling and monitoring of expiration dates are adhered to as intended. Using daily rounds tool, under the direction of the DON; Resident care managers will check all medication carts daily to ensure all carts are locked and no medications are left on top of the Medication and treatment carts. The DON will make weekly rounds to visually monitor medication carts, treatments carts and medication rooms to ensure compliance processes are being followed strictly. The DON will further discuss medication storage issues in monthly CQI meetings.	10-10-13	

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F 441	<p>Continued From page 35</p> <p>Not ensuring the dietary staff washed their hands after handling soiled items increase the risk of cross contamination.</p> <p>DINING SERVICES</p> <p>During observation of the meal service on 8/27/13, on the first floor, Staff C was observed helping a resident wash their face with a washcloth. After the cloth was placed in a soiled laundry container, the staff then remove the gloves disposed of them and then assisted a resident out of the dining room, by pushing a wheelchair. Staff C did not wash and/or sanitize her hands after removing the soiled gloves.</p> <p>An additional Licensed Nurse, Staff L, assisted the resident to wash; after handling the soiled laundry the staff removed the gloves discarded them in the garbage and assisted a resident out of the dining room by pushing their wheelchair out of the area. Staff L, then returned to the dining room within two minutes and cued a resident to consume fluids by handing them a drink from their tray. The staff did not wash their hands after handling the soiled linens.</p> <p>RESIDENT CARE AND TRANSFER EQUIPMENT</p> <p>Resident #62 was admitted to the facility on 10/07/2010 for total care resulting from multiple medical diagnosis to included dementia related psychosis.</p> <p>On 08/23/2013 at 1:30 p.m. Staff Z was observed wearing gloves as he transferred Resident #62 via Hoyer lift to her bed. Staff Z was assisted by an unnamed student nurses' aide. Staff Z</p>	F 441	<p>F441</p> <p>It is the policy of Leon Sullivan Health Care Center to prevent any infectious diseases from spreading. The facility has infectious disease tracking system on all units in the building. Gathered information is collected every month by the infection control nurse, analyzed and discussed in CQI meetings. The facility also follows strict hand washing and changing of gloves policy and procedures.</p> <p>Actions taken for the cited deficiency</p> <p>Linen cart has been removed from the third floor</p> <p>Third floor storage room is turned into a locked clean linen room only accessible to staff members.</p> <p>Staff Development Coordinator attended Center for Geriatric infection control workshop on 9/10/2013 and returned to the facility with information on how to set up infection control program for the facility. The knowledge acquired in the Geriatric Infection control training will assist the Infection Control nurse with educating staff on best infection control</p>	10-10-13

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F 441	<p>Continued From page 36</p> <p>preceded to remove attends and clean resident peri and buttocks area with disposable wipes. Staff Z swiped the peri area with one wipe 3 times without rotating which would prevent cross contamination. Once the skin was clean the soiled supplies were bagged and Without changing gloves, Staff Z proceeded to place the clean attends on the resident without changing his gloves.</p> <p>Wearing the same gloves, Staff Z and the student adjusted the bed spread and sheet, moved the call light, adjusted the resident's pillow under her head and drew back the privacy curtain. Without removing his gloves, Staff Z the took the Hoyer lift from the resident's room, walked it down the hall and placed it in the storage room at the North end of the 3rd floor and left it without cleaning the equipment.</p> <p>Record review of the pharmacy monthly regimen review indicated the resident had been treated for a urinary tract infection 3 times a year for the past 3 years.</p> <p>DRESSING CHANGE</p> <p>Resident #30 was admitted [REDACTED] 2012 to the facility with diagnoses including [REDACTED] Dysphagia (difficulty swallowing) and is fed via a tube entering the stomach from the abdominal wall.</p> <p>On 08/27/13 at 4:00 pm during an observation of Resident #30's dressing change and cleansing of the opening in the abdominal wall through which the tube enters the stomach, the Registered Nurse, Staff K, did not follow facility Hand Washing Procedures. Prior to removing the dressing on the abdominal wall where the feeding</p>	F 441	<p>F441 continued</p> <p>practices, creating trending reports and how to engage other team members in the facility.</p> <p>Because this cited deficiency potentially affected all residents and employees, under the direction of the DON, the infection control nurse will in-serviced all staff on:</p> <p>Hand washing and gloving policies and procedures, food handling procedures, isolation techniques or procedures, urinary catheterization and UTI, handling/transporting dirty or solid linen, dining room etiquette and wound care.</p> <p>The Infection Control Nurse will complete monthly infection control logs that indicate how that information can be used to prevent transmission of infections in the facility and submit to the DON for review.</p> <p>Monitoring</p> <p>Using the rounds tool, RCMs/Infection Control Nurse will conduct weekly rounds and observe for proper hand washing, linen handling, gloving,</p>	10-10-13	

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F 441	Continued From page 37 tube enters the abdomen, Staff K washed and gloved his hands. Just before removing the dressing, Staff K, used his gloved hands and pulled the trash can over to the resident's bedside and then proceeded to remove the abdominal wall dressing. Staff K did not rewash and re-glove his hands after touching the trash can. On 08/28/13 at 1:43 pm during an interview with Staff C, Resident Care Manager, she stated if the trash can was touched the nurse should remove their gloves and wash their hands prior to continuing with the dressing change. Review of Facility Policy and Procedure of Hand Washing states: "Purpose: To help stop the spread of infection." and "Gloves must be thrown away after each task or when they get damaged or dirty." HANDLING LINENS On 08/26/2013 at 3:50 p.m. Resident # 158 was observed removing linen from the 3rd floor south linen cart without assistance while seated in his wheelchair. He draped the linen cart cover over his back and took linen. In an interview at 4:00 p.m. Resident # 158 stated he gets his linen from the cart regularly without assistance. On 08/27/13 at 2:15 p.m. two unnamed residents were observed removing linen from the 3rd floor south linen cart with the assistance of a NAC. Observation on 08/30/13 at 08:45 a.m. revealed Staff AA carried bath blankets against shirt while moving blankets out of the laundry room. Interview with Staff BB revealed facility policy was not to let linen come in contact with staff clothing. Observation at 09:15 a.m. revealed Staff CC planned to assist resident #177 in shower which was a regular occupational therapy service Staff CC provided to clients. Staff CC carried the resident 's linen held against his shirt. Staff CC	F 441	F441 continued incontinence care, wound care and dressing changes to ensure compliance with infection control policy and procedures. Kitchen Director/Designee will conduct daily rounds to observe for proper hand washing and usage of gloves in the Kitchen. Under the direction of the DON, using the quality assurance audit tool, Quality Assurance Nurse/Infection Control Nurse will conduct quarterly procedural audits to ensure proper hand washing, linen handling, gloving, incontinence care, wound care, and dressing changes to ensure compliance with infection control policy and procedures. The DON will make rounds with the Inflection Control Nurse and observe infections control practices once a month to ensure the inflection control process is implemented effectively. Compliance will further be reviewed in monthly CQI meetings.	10-10-2	

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F 441	<p>Continued From page 38 stated he had not been trained to carry linen used by the residents away from his body/not against his clothes.</p> <p>RESIDENT #30</p> <p>Resident #30 was admitted [REDACTED] 2012 to the facility with diagnoses including [REDACTED] Dysphagia (difficulty swallowing) and is fed via a tube entering the stomach from the abdomen wall.</p> <p>On 08/27/13 at 4:00 pm during an observation of Resident #30's dressing change and cleansing of the opening in the abdominal wall through which the tube enters the stomach, the Registered Nurse, Staff K, did not follow facility Hand Washing Procedures. Prior to removing the dressing on the abdominal wall where the feeding tube enters the abdomen, Staff K washed and gloved his hands. Just before removing the dressing, Staff K, used his gloved hands and pulled the trash can over to the resident's bedside and then proceeded to remove the abdominal wall dressing. Staff K did not rewash and reglove his hands after touching the trash can.</p> <p>On 08/28/13 at 1:43 pm during an interview with Staff C, Resident Care Manager, she stated if the trash can was touched the nurse should remove their gloves and wash their hands prior to continuing with the dressing change.</p> <p>Review of Facility Policy and Procedure of Hand Washing states: "Purpose: To help stop the spread of infection." and "Gloves must be thrown away after each task or when they get damaged or dirty."</p>	F 441	<p>F496</p> <p>Leon Sullivan Health Care Center has NACs, NARs and O.B.R.A Registration policy and procedures in place.</p> <p>HR provides license renewal reminders to all NACs and Licensed Nursing staff 30-40 days before their birth dates.</p> <p>Employees with expired licenses are not allowed to work until they renew their licenses.</p> <p>NACs or NARs that are not registered with O.B.R.A or fail to renew their Licenses are not also allowed to work for the facility.</p> <p>Leon Sullivan Health Care Center Staff development checks all the necessary documents and criminal backgrounds before hiring any employee.</p> <p>Corrective Action taken for the alleged deficiency</p> <p>Staff H was dismissed.</p> <p>Because all hiring policies and procedures are potentially affected by this citation, under the direction of the administrator, the staff development coordinator will audit all employee files and those who are directly or indirectly involved in the hiring</p>	10/01/13	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505511	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/30/2013
NAME OF PROVIDER OR SUPPLIER LEON SULLIVAN HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2611 SOUTH DEARBORN SEATTLE, WA 98144	

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<p>F 496</p> <p>F 496</p> <p>SS=D</p>	<p>Continued From page 39</p> <p>483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING</p> <p>Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.</p> <p>Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual.</p> <p>If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to verify the OBRA Registry had been completed and/or updated for 1 of 3 sampled</p>	<p>F 496</p> <p>F 496</p>	<p>F496 continued process will be in-serviced on policies and procedures of hiring and license renewal and abuse prevention.</p> <p>Actions taken to ensure solutions to the cited deficiency are sustained and reoccurrence prevented.</p> <p>The staff development coordinator will audit all new employees' credentials and criminal background before hiring any nursing staff.</p> <p>Nursing professionals with inactive licenses will not be allowed to work for the facility.</p> <p>Monitoring</p> <p>The Administrator will meet with staff development coordinator once every three months and audit all employees' files to ensure facility's performance related to verification of licenses and registry is sustained per policy.</p> <p>The Administrator will also use employees' information/birth dates in the non-shard facility's data to monitor registry/licenses renewal issues quarterly.</p> <p>Compliance will be reviewed in the monthly CQI meeting.</p>	<p>10-10-13</p>

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