

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

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1/29/16

PRINTED: 01/25/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505512</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/19/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARDEN TERRACE HEALTHCARE CENTER OF FEDERAL WAY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>491 SOUTH 338TH STREET FEDERAL WAY, WA 98003</b>		
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Garden Terrace Healthcare Center of Federal Way on 01/11/16, 01/12/16, 01/13/16, 01/14/16, 01/15/16 and 01/19/16. A sample of 25 residents was selected from a census of 51. The sample included 20 current residents and the records for 5 former and/or discharged residents.</p> <p>The following were complaints investigated as part of this survey: #3180405</p> <p>The survey was conducted by: Lisa Foster, RN, MN Jennifer Alley, MSW Kathy Wrynn, RN, MN George Foley, RN</p> <p>The survey team is from: Department of Social and Health Services Aging and Adult Services Administration Residential Care Facilities Region 2, Unit F 20425 72nd Avenue South, Suite 400 Kent, Washington 98032-2388</p> <p>Telephone: (253) 234-6000 Fax: (253) 395-5070</p> <p><i>Mike Ankerke</i> 01/25/16 Residential Care Services Date</p>	F 000			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *MBA* TITLE *Executive Director* (X6) DATE *2/5/16*

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 272 SS=D	<p><b>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</b></p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:                      Identification and demographic information;                      Customary routine;                      Cognitive patterns;                      Communication;                      Vision;                      Mood and behavior patterns;                      Psychosocial well-being;                      Physical functioning and structural problems;                      Continence;                      Disease diagnosis and health conditions;                      Dental and nutritional status;                      Skin conditions;                      Activity pursuit;                      Medications;                      Special treatments and procedures;                      Discharge potential;                      Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and                      Documentation of participation in assessment.</p>	F 272	<p><i>"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."</i></p> <p><b>F-272</b></p> <p><u>Individual Residents</u>                      Resident #134 no longer resides at the facility, residents #152 and #288 MDS were modified regarding dental issues and Oral Assessments were updated. Resident #61 was interviewed and the MDS has been updated, Unable to update the Hospice section, as the MD does not feel the resident has Less than 6 Month Prognosis therefor the facility will be contacting Hospice to assess whether Hospice is still appropriate. Resident #185 MDS was updated to state she was not interviewable. resident #292 received the BIMS and MOOD interview and MDS was updated.</p> <p><u>Residents in similar situations</u>                      MDSs were audited for Dental, Hospice, BIMS and Mood section and updated if needed.</p> <p><u>Measures to prevent reoccurrence</u>                      MDS and Social Services were educated on ensuring correct MDS assessments and coding are done.</p>		

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F 272	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to accurately assess six (#s 134, 288, 152, 61, 185 &amp; 292) of 18 sampled residents who were included in the Stage 2 Review. Failure to ensure accurate assessments regarding pressure ulcers, dental status, hospice, terminal prognosis and communication status placed residents at risk for unidentified and / or unmet needs.</p> <p>Findings include:</p> <p><b>RESIDENT #134</b> According to the 09/17/15 Minimum Data Set (MDS), staff assessed Resident #134 to have no [REDACTED] but was at risk for the development of [REDACTED]. According to the quarterly MDS dated 12/05/15, Resident #134 had a [REDACTED] which was assessed to be 2.2 cm (centimeters) by 1.4 cm and was 4.5 cm deep.</p> <p>In an interview on 01/19/16 at 8:42 a.m., Staff H (Nurse Consultant) indicated the depth on the 12/05/15 MDS was incorrect as it referred to tunneling, not the depth of the wound.</p> <p><b>RESIDENT #288</b> Resident # 288 admitted to the facility on [REDACTED] 6 with multiple medically complex diagnoses. According to an oral assessment form dated 01/04/16, Resident #288 had no teeth, but had full dentures.</p> <p>In an interview on 01/11/16 at 1:38 p.m., Resident #288 indicated she had problems with her teeth. The resident elaborated she had some "rotten"</p>	F 272	<p><b>F-272 (Cont.)</b></p> <p><u>On-going Monitoring</u> Audits of dental, BIMS, Mood and Hospice will be conducted weekly x 4 weeks and then monthly for 2 months. Audits will be presented to the DON. Negative findings of the audits will be presented to the monthly QAPI committee x3 months for further education and training opportunities</p> <p><u>Individual to Ensure Compliance</u> Director of Nursing or Designee will ensure compliance.</p> <p>Date of Compliance: 02/25/2016</p>	

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F 272	<p>Continued From page 3</p> <p>and missing teeth and stated she did not have dentures. Observation at that time confirmed the resident had multiple broken/carious and or missing teeth and did not utilize dentures.</p> <p>In an interview on 01/19/16 at 7:36 a.m. Staff G (MDS Coordinator) indicated the 01/11/16 MDS reflected the resident had no natural tooth fragments and was edentulous (without teeth).</p> <p>Observation with Staff E on 01/19/16 at 8:15 a.m. confirmed the resident had multiple broken/carious teeth including: two on the lower left jaw, one on the lower right, one on the upper left and two on the upper right. Staff E confirmed the resident had multiple intact teeth and did not utilize dentures. Upon review of the 01/04/16 oral assessment form, Staff E confirmed the assessment and the MDS were incorrect and did not accurately reflect the resident's oral status.</p> <p>RESIDENT #152 On 01/12/16 at 1:15 p.m. Resident #152 was observed with only lower front teeth, which were in poor repair. In an interview at that time, Resident #152 said at the next dentist appointment "they will probably pull them all." Resident #152 indicated he had upper dentures, which he did not wear as "they don't work good anymore." In addition, Resident #152 had a lower plate which he did not wear as it "doesn't fit good now either."</p> <p>Review of the resident's record revealed a 12/18/15 Oral Assessment form which indicated the resident was assessed with dental decay noted on bottom teeth, missing multiple lower teeth, and missing all upper teeth. The 12/18/15 Nutrition Data Collection/Assessment revealed:</p>	F 272			

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F 272	<p>Continued From page 4</p> <p>the resident's chewing ability required mechanically altered diet. The noted condition of dentition was "missing/decayed teeth."</p> <p>According to the 12/23/15 MDS dental section, the resident did not have any broken or loosely fitting full or partial dentures, no obvious or likely cavities or broken natural teeth. Similar assessment was included on the 12/30/15 MDS.</p> <p>In an interview on 01/14/16 at 1:36 p.m. Staff K indicated the MDS should have accurately reflected the resident's decayed teeth.</p> <p>RESIDENT #61</p> <p>Review of Resident #61's record revealed she admitted to hospice on [REDACTED] 15. According to the 07/09/15 Change in Condition MDS, the resident did not receive hospice services during the reference period (Section O indicated "None of the Above while a resident"). In an interview on 01/14/16 at 1:27 p.m. Staff G stated Hospice should have been selected as "That's the reason we did the Change in Condition MDS".</p> <p>In addition, according to the 07/09 and 10/09/15 MDS assessments, Section J indicated the resident did not have a condition or chronic disease that "may result in a life expectancy of less than 6 months." According to the Resident Assessment Instrument (RAI) Manual, the facility was directed to code yes to this section if "the resident is receiving hospice services."</p> <p>In an interview on 01/14/16 at 1:29 p.m. Staff G stated the assessments should have identified the resident with a terminal prognosis based on the RAI manual directions.</p>	F 272		

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F 272	<p>Continued From page 5</p> <p>According to the 04/09, 07/09 and 10/09/15 MDS assessments, the resident was assessed as usually understood and usually understands others. These same assessments then identified the Brief Interview for Mental Status (BIMS) and the Mood interview should not be conducted due to the resident was "rarely/never understood".</p> <p>On 01/14/16 at 1:21 p.m., Staff G reviewed the MDS assessments in question and the RAI Manual. She stated both the BIMS and Mood interviews should be attempted if the resident was anything other than "Rarely/Never Understood". She stated there were directions on how to code if the resident was not able to complete the interviews, and that should have been done in these instances. She acknowledged the interviews should have been attempted and the MDS coded to indicate that.</p> <p><b>RESIDENT #185</b> Similar findings were identified for Resident #185 who, according to the 10/29/15 MDS, was assessed as usually understood and usually understands others. The same MDS then identified the BIMS and the Mood interview should not be conducted due to the resident was rarely/never understood.</p> <p>On 01/14/16 at 1:23 p.m., Staff G stated the interviews should have been attempted and coded appropriately if the resident was unable to complete them.</p> <p><b>RESIDENT #292</b> Similar findings were identified for Resident #292 who, according to the 01/06/16 MDS, sometimes understands and sometimes understood. However, neither the BIMS or the Mood interview</p>	F 272			

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F 272	Continued From page 6 were attempted and staff coded the reason as "resident is rarely/never understood."	F 272		
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to develop and/or revise comprehensive care plans for six (#s 61, 63, 292, 185, 124 &amp; 144) sampled residents of the 19 residents whose care plans were reviewed in Stage 2. Failure to establish care plans that accurately reflected assessed care needs and provided direction to staff on the</p>	F 279	<p><b>F-279: Care Plans</b></p> <p><u>Individual Residents</u> The interdisciplinary team (IDT) completed a comprehensive care plan review for resident # 61, #292 and #185. #124, # 63, #144 no longer reside at the facility. Care Plans/Care Directives were updated on these residents in regards to; Preferred Name, Incontinence and Infection.</p> <p><u>Residents in similar situations</u> IDT will review resident care plans and care directive and revise comprehensive care plans on residents identified with issues of; Incontinence, Infection, Anticoagulation Use, residents with a Preferred Name and Wandering/Elopement Risk residents in conjunction with the MDS schedule.</p> <p><u>Measures to prevent reoccurrence</u> Director of Nursing or designee will educate the MDS and RCM's on the development of comprehensive care plans for Incontinence, Infection, Wandering/Elopement Risk Residents, residents with a Preferred Name and Anticoagulation Use.</p>	

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F 279	<p>Continued From page 7</p> <p>residents' care related to preferences, incontinence, infection, wandering and medication use placed residents at risk to receive less than adequate care.</p> <p>Findings include:</p> <p><b>RESIDENT #61</b> Resident #61 admitted to the facility in 2014. Review of the admission Social Service Assessment and Activities Evaluation, Resident #61 was an accomplished military officer and physician. These assessments, as well as the Activities Preference Care Plan (CP), dated 10/21/15, revealed Resident #61 preferred to be called a specific title by staff.</p> <p>Observation throughout the survey revealed Resident #61 was consistently called her first name by staff. Nursing staff, therapy staff and activity staff were all observed to call Resident #61 by her name and not the title identified in the care plan.</p> <p>On several occasions throughout the survey, Resident #61 was greeted by the surveyor by the noted preferred title. Resident #61 did not respond to any of the greetings, nor did she respond to direct questions. She appeared cognitively impaired.</p> <p>In an interview on 01/19/16 at 8:54 a.m., Staff D stated "It's probably a care plan issue. She doesn't really seem to mind what we call her." Staff D further explained the resident's responsible party, who visited frequently, no longer called the resident by the preferred title, and she did not think the resident necessarily recognized when spoken to due to her cognitive</p>	F 279	<p><b>F-279: Care Plans (Cont.)</b></p> <p><u>On-going Monitoring</u> The Resident Care Managers or designee review care plans in conjunction with the resident's MDS schedule, order changes and new admissions to ensure care planning is reflective of current needs. Audits will be reviewed by the Director of Nursing and negative findings of the audits will be presented to the monthly QAPI committee x3 months for further education and training opportunities.</p> <p><u>Individual to Ensure Compliance</u> The Director of Nursing or Designee will ensure compliance.</p> <p><u>Date of Compliance</u> February 25, 2016</p>		

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F 279	<p>Continued From page 8 loss. Staff D stated, "I need to update the care plan."</p> <p><b>RESIDENT #63</b> According to the 11/26/15 Minimum Data Set (MDS) assessment, Resident #63 was totally dependent on two staff for most activities of daily living, including transfers and toileting. This MDS also assessed the resident had not had a trial toileting program, such as scheduled toileting or prompted voiding, attempted. In addition, the resident was assessed with severely impaired vision and hearing, no speech and severe cognitive loss.</p> <p>Review of the Incontinence CP, dated 08/31/15, included a goal that the resident would "... have toileting to minimize episodes of incontinence." Approaches included numerous interventions related to scheduled toileting including "adjust toileting schedule as needed...; Explain toileting program to family including goals, voiding pattern and determined toileting schedule; observe for non-verbal cues that the resident may need to use the toilet outside of regular toileting; provide reassurance to resident for incontinent episodes that occur between toileting times; and provide assist with toileting upon rising, before/after meals" at bedtime, upon request and when restless.</p> <p>In an interview on 01/15/16 at 8:43 a.m., Staff F stated the Incontinence CP included an inaccurate goal and approaches as the resident was on a "check and change program" due to her debilities. "I'm surprised I didn't catch that."</p> <p><b>RESIDENT #292</b> Similar findings were identified for Resident #292</p>	F 279		

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F 279	<p>Continued From page 9</p> <p>whose Incontinence CP, dated 01/01/16, included the exact same goal and approaches as Resident #63's. In an interview on 01/19/16 at 8:34 a.m., Staff N stated the resident was on a "check and change" program, meaning she was incontinent and staff provided all incontinent care. In an interview on 01/19/16 at 8:27 a.m., Staff D stated the care plan needed updated.</p> <p><b>RESIDENT #185</b> Similar findings were identified for Resident #185 whose Infection CP, last reviewed 11/05/15, noted the resident with an "active infection in urine" and listed two antibiotics prescribed 08/30/15. Approaches included "08/29/15 UTI (urinary tract infection)". In an interview on 01/19/16 at 8:25 a.m., Staff D stated the Infection CP needed updated as the resident no longer had an active infection.</p> <p><b>RESIDENT #124</b> According to the 07/25/15 MDS, Resident #124 wandered 1-3 days during the seven day lookback period. The wandering was assessed to place the resident at significant risk of getting to a potentially dangerous place. Review of the Care Area Assessment revealed the resident had "an episode of exit seeking which was easily redirected."</p> <p>Record review revealed a 07/25/15 9:47 a.m. progress note that, "Resident very impulsive, attempting to stand numerous times this shift, easily re directed, resident wheeling self to door to hallway wanted to go home was redirected...". A 07/26/15 8:49 p.m. progress note documented, "...Resident agitated, attempting to leave unit and was striking out when trying to redirect...".</p>	F 279		

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F 279	<p>Continued From page 10</p> <p>The Risk of Elopement/wandering review, dated 07/20/15, revealed the resident was not at risk for elopement/wandering at that time. The facility failed to reassess the resident to identify the level of risk or implement safety interventions.</p> <p>Further review of the resident's record revealed no CP that addressed the resident's wandering or exit seeking behavior.</p> <p>In an interview on 01/19/16 at 9:38 a.m. Staff L said that during the MDS observation period the resident was at the door attempting to get out and as a result the MDS was coded as wandering. When informed the facility failed to develop a care plan following the assessment, Staff L replied, "okay".</p> <p><b>RESIDENT #144</b> Resident #144 admitted to the facility on [REDACTED] 15 with multiple medical issues including [REDACTED] and a physician's order for the [REDACTED] injection every 12 hours.</p> <p>According to the 12/20/15 MDS, the resident received injections and [REDACTED] medication on all seven days of the assessment period.</p> <p>In an interview on 01/14/16 at 10:22 a.m. Staff C verified the resident continued to receive [REDACTED] and indicated the resident would be on it permanently. Staff C said in preparation for discharge home the resident had been trained to self administer the medication and the facility was working on getting the resident on a program where the medication would be provided free of charge. Staff C indicated precautions to be</p>	F 279		

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F 279	Continued From page 11 followed while on the medication included using an electric razor rather than a blade razor and monitoring for bleeding. Staff C said she believed the resident had an [REDACTED] care plan and was surprised there was not one.  In an interview on 01/14/16 at 1:45 p.m. Staff G said the [REDACTED] CP should have been completed on admission. In addition, if the CP was not done it should have been when the MDS was completed.	F 279		
F 309 SS=D	<b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b>  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 it was determined the facility failed to ensure three (#s 295, 152 & 284) of six sampled residents reviewed in Stage 2 received the necessary care and services to attain or maintain their highest practicable level of well being. Failure to ensure staff identified and monitored skin issues for two (#s 295 & 152) of three residents reviewed for non-pressure skin conditions or provided appropriate positioning for one (#284) of three residents reviewed for positioning had the potential for these residents to	F 309	<b>F-309: PROVIDE CARE AND SERVICES FOR HIGHEST WELL BEING</b>  <u>Individual Residents</u> Residents # 295 and #284 no longer reside at the facility. Resident #152 was assessed for bruises and Care Plan and Monitoring were updated accordingly per MD Order.  <u>Residents in similar situations</u>  Residents admission and weekly skin checks for the last 14 days were reviewed for bruising to ensure proper monitoring was implemented with specific location of bruise's, Incident reports were done for any bruises that were not identified on admission, residents were assessed for the need of "nail care" and referred to the Podiatrist as needed.	

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F 309	<p>Continued From page 12 experience worsening/untreated skin conditions, uninvestigated abuse/neglect and discomfort.</p> <p>Findings include but are not limited to:</p> <p><b>NON-PRESSURE SKIN RESIDENT #295</b> Resident #295 admitted to the facility on [REDACTED] 16 with care needs related to complications secondary to a fall. According to the 01/08/16 Minimum Data Set (MDS), the resident was assessed to require two person extensive assistance for bed mobility and transfers and one person moderate assistance for personal hygiene. This MDS also reflected the resident was understood and able to understand conversation and had no cognitive impairment.</p> <p>Observation on 01/11/16 at 2:09 p.m. revealed Resident # 295 had elongated fingernails and bruises to the left arm below the elbow.</p> <p>A weekly head to toe skin assessment completed by the facility on 01/12/16 indicated the resident had "old, almost resolved bruises" but did not indicate their location and did not identify the resident had long nails.</p> <p>Observation on 01/13/16 at 10:56 a.m. revealed the resident lying in bed without socks. The resident's toe nails were noted to be long with the nails on the first two toes of both feet being jagged. Multiple bruises were noted on the resident's feet, including a moderate sized bruise on the top of the right foot. In an interview at that time, Resident #295 stated her nails were, "...a tad long." The resident also indicated no one had offered to trim her nails since she had been in the facility and that previously, she went to a</p>	F 309	<p><b>F-309: PROVIDE CARE AND SERVICES FOR HIGHEST WELL BEING (Cont.)</b></p> <p><u>Measures to prevent reoccurrence</u> Licensed Staff were educated by the director of nursing or designee on documentation of skin issues, i.e. bruises on admission, to monitor specific bruises separately per MD Order, implementing and updating care plans pertaining to skin issues, assessing "nails" during weekly skin checks and showers, referring to Podiatry as needed and reporting injuries when providing cares to the LN/DNS so an Incident Report can be completed including ruling out abuse and neglect.</p> <p><u>On-going Monitoring</u> RCMs will audit Skin Checks, including New Admission Skin Checks and TAR'S for documentation of bruising and any new skin issues daily (M-F) x30 days, and then weekly x2 months for compliance. Referrals will be placed to Podiatrist as needed.</p>		

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F 309	<p>Continued From page 13 podiatrist to have her toenails trimmed.</p> <p>Observation on 01/14/16 at 8:47 a.m. revealed the resident's fingernails were now trimmed. When asked when the nails were trimmed the resident replied, "They got 'em last night at 10:00 p.m.!! And they made me bleed! They got the skin and the nails." The resident elaborated that staff cut her toe during nail care.</p> <p>In an interview on 01/14/16 at 10:51 a.m., Staff E indicated, "We tried last night (to trim Resident #295's toenails) but it was too thick... she has very thick nails... we tried to cut she said, 'I want a Podiatrist'." Staff E elaborated the care plan had been changed the previous day to include that the resident preferred a Podiatrist trim her toenails and the resident was added to the list to be seen by the Podiatrist.</p> <p>Record review revealed no indication facility staff had tried and failed to provide nail care, nor was there any indication the resident had sustained an injury during care.</p> <p>Upon removal of the resident's socks, at 01/14/16 at 10:58 a.m., Staff E identified the resident's second toe on the left foot was bloody from the tip to the base and uttered, "Oh no, no." The resident stated, "I feel it now, but it really hurt last night... I think it's gotten a little numb with time... clippers are viscous...".</p> <p>Upon cleansing the second left toe, Staff E identified a 0.3 x 0.1 centimeter (cm) cut to the medial tip of the resident's second left toe proximal to the toenail. After further assessment of Resident #295's lower extremities, Staff E described the following skin issues: a 1.2 cm x</p>	F 309	<p><b>F-309: PROVIDE CARE AND SERVICES FOR HIGHEST WELL BEING (Cont.)</b></p> <p>Therapy will assess proper positioning for wheel chairs for residents, including foot rest and lap tray positioning on admission and on-going while under therapy services. Audits will be presented to the DON. Negative findings of the audits will be presented to the monthly QAPI committee x3 months for further education and training opportunities.</p> <p><u>Individual to Ensure Compliance</u> The Director of Nursing or Designee will ensure compliance.</p> <p><u>Date of Compliance</u> February 25, 2016</p>	

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F 309	<p>Continued From page 14</p> <p>0.1 cm bruise on the right great toe; a "bluish" 4.5 cm by 3.5 cm bruise on the top of the right foot; a 1.5 cm by 1.0 cm purple bruise on the lateral right foot; a 4.0 cm x 2.0 cm resolving bruise on right lateral foot which appeared to be fading; a 0.8 cm x 0.5 cm purple bruise on the base of the left great toe; a 0.3 cm x 0.3 cm purple bruise on the left lateral foot; and a 0.4 cm x 0.4 cm purple bruise on the lateral tip of third right toe. None of these bruises were identified on the 01/12/16 skin assessment nor was there evidence that any direct care staff reported the bruises or the cut toe.</p> <p>In an interview on 01/14/16 at 12:11 p.m., Staff E indicated direct care staff should have identified and reported the resident's bruising. Staff E indicated the resident should have been seen by the Podiatrist as directed by the care plan and that she would expect staff to report the cut toe at the time of the injury. Failure to report injuries detracted from staff's ability to rule out abuse/neglect and placed the resident at risk for delayed treatment and monitoring of bruises/wounds.</p> <p>Additionally, according to the facility policy on Foot Care, staff were to "fill basin half full of warm water... (and) wash feet well and soak approximately 10 minutes..." prior to clipping and filing toenails.</p> <p>In an interview on 01/19/16 at 10:00 a.m. the resident stated, "It's (the injured toe) been sore as the devil since they cut it...". When asked if the staff who trimmed the nails was aware of the injured toe, Resident #295 stated, "Yeah, she knew, she said, 'strike one' then she asked me if I was diabetic because I was bleeding so, I told her</p>	F 309			

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F 309	<p>Continued From page 15</p> <p>no...". When asked if staff soaked her foot or bathed her prior to trimming her toe nails the resident responded, "No, she didn't soak 'em, just grabbed 'em and started snippin'...". Failure to follow facility protocol for foot care placed the resident at increased risk for injury during nail care.</p> <p><b>RESIDENT #152</b> On 01/12/16 at 1:13 p.m. Resident #152 was observed with bruises on both hands, wrists, arms, and elbows. The resident had more bruises to the right upper extremity than the left. In an interview at that time, Resident #152 said "I bruise real easily." The resident elaborated that following a recent [REDACTED] "It was hard for a while" and demonstrated with a flailing right arm bumping into things.</p> <p>Record review revealed a [REDACTED] 15 admit note, "...Resident has scattered bruising to his Lt. (left) hand and forearms. Large purple bruise to dorsum of Rt. (Right) hand measures approx 6 x 5 cm. Resident states he bruises very easily. Denies being harmed by caregivers. Resident has small purple bruise to his Lt abd(omen) which appears to be secondary to an injection...".</p> <p>Physician Orders dated 12/18/15 instructed staff to "monitor bruises to BUE (bilateral upper extremities) til resolved daily", and "Skin assessment weekly".</p> <p>Review of the December 2015 and January 2016 Treatment Administration Records (TAR) revealed the monitoring of the resident's BUE bruises was scheduled to be done on a weekly rather than daily basis as ordered. In addition, staff failed to document monitoring of the bruising</p>	F 309		

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F 309	<p>Continued From page 16 as scheduled on 01/06/16 or 01/13/16.</p> <p>Review of the weekly skin integrity data collections revealed the first documented weekly skin assessment was undated. The undated assessment indicated the resident had bruises/skin discoloration to bilateral upper extremities. There was no indicated measurements of size or indication of healing/resolving. The 01/03/16 and 01/10/16 weekly skin assessments indicated the resident had bruises but failed to identify the location of the bruises, size or status of healing.</p> <p>Review of the progress notes revealed no further assessment or documented monitoring of the bruises.</p> <p>In an interview on 01/14/16 at 2:46 p.m. Staff C said "usually bruises are listed separately and not all together" and "monitored daily until resolved." In addition, Staff C confirmed there was no documented monitoring of the resident's bruises January 1 through 14, 2016 and said "we need to do a better job."</p> <p>POSITIONING RESIDENT #284 Resident #284 admitted to the facility on [REDACTED] 16 following hospitalization for a [REDACTED] with [REDACTED]</p> <p>According to the 01/11/16 Occupational Therapy (OT) Evaluation, the resident required maximum assistance for siting balance with verbal cues to decrease [REDACTED] leaning. The documented plans were for the resident to receive both skilled OT and Physical Therapy six times a week.</p>	F 309			

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F 309	<p>Continued From page 17</p> <p>Resident #284 was observed on 01/12/16 at 1:20 p.m. seated in a wheelchair with both feet resting on top of towels which had been folded and placed on top of the footrests.</p> <p>On 01/13/16 at 9:40 a.m. Resident #284 was observed seated in the wheelchair with the soles of both feet facing each other, so the outer edges of the resident's feet rested on the folded towel. In addition the resident's left arm rested on a half lap tray, which raised the resident's left shoulder and contributed to the resident's [REDACTED] leaning.</p> <p>Similar findings were observed on 01/14/16 at 8:51 a.m. except there were not folded towels on the foot rests. As a result, the resident's feet were not fully supported by the foot rests and were partially dangling. Similarly on 01/15/16 at 8:01 a.m. the resident was observed with the left foot resting on the heel sling peg and only the right toes resting on the footrest.</p> <p>On 01/19/16 at 7:57 a.m. the resident was observed with the half lap tray in place, her upper body leaning to the right. The resident's feet were on a bed pillow which had been placed on top of the footrests.</p> <p>Review of the PT/OT progress notes and the resident's plan of care revealed no assessment or plan regarding the resident's wheelchair footrests or plan to correct the resident's dangling feet.</p> <p>In an interview on 01/19/16 at 8:53 a.m. when informed the resident's feet did not rest on the foot pedals, Staff O, OT said, "Right, we put towels under her feet and rehab is looking for shorter foot rests." When informed the half lap</p>	F 309		
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F 309	Continued From page 18 tray was high, raising the resident's left shoulder and to compensate the resident was observed to lean to the right, Staff O said "She hasn't complained of pain in that arm, I've asked her." Staff O added "the arm should be positioned further (out towards the end of the tray)." In addition, Staff O indicated therapy staff were working on the resident's trunk strength.  In an interview on 01/19/15 at 9:08 a.m. Staff P, Rehab Aide, said the resident had "standard foot rests, which are adjustable, but I need to get her foot rests with bolts that I can bring way up."  Failure to ensure the resident was properly positioned by timely assessing and implementing interventions placed her at risk for pain and foot drop.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to prevent, timely identify, monitor and/or evaluate interventions for	F 314	<b>F-314</b>  <u>Individual Residents</u> Resident #134 no longer resides in the facility.  <u>Residents in similar situations</u> Facility will audit all skin checks with current residents and investigate any unknown/untreated findings. Facility will ensure any new findings with have the proper documentation and treatments, per facility policy.	

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F 314	<p>Continued From page 19</p> <p>pressure ulcers for one (#134) of two residents reviewed for pressure ulcers. Failure to timely identify a pressure ulcer for Resident #134 caused a delay in implementation of interventions. Failure to ensure accurate assessment/ monitoring of skin placed Resident #134 at risk for worsening of an identified Stage I pressure ulcer.</p> <p>Findings include:</p> <p>RESIDENT #134 Resident #134 admitted to the facility on [REDACTED] 15 with diagnoses including [REDACTED] infection and [REDACTED]. According to the 09/17/15 Minimum Data Set (MDS), the resident was assessed to require extensive two person assistance for bed mobility, transfers, and personal hygiene. This MDS indicated the resident had no Pressure Ulcers (PUs), was at risk for the development of PUs and was not on a turning/repositioning program. According to the 12/05/15 MDS, the resident had developed a Stage III PU that was not present upon admission.</p> <p>Resident #134 discharged from the facility on [REDACTED] 15 and was unavailable for interview or observations.</p> <p>According to an unsigned weekly skin integrity document dated 09/15/15, the resident was assessed to have "redness" to the coccyx area, but there was no indication of size or blanchability (indication of PU). A skin assessment on 09/16/15 indicated the resident now had an incision to the same identified area as where the redness was identified on 09/15/15, however the only documentation of a surgical incision was not in the coccyx area.</p>	F 314	<p><b>F-314 (Cont.)</b></p> <p><u>Measures to prevent reoccurrence</u> Licensed Staff will be in-serviced by DON or designee on identifying skin issues in a timely manner and follow facility protocol for new skin issues.</p> <p><u>On-going Monitoring</u> Skin checks, including admission skin assessments will be monitored daily x 30 days, then will occur weekly x2 months. Negative findings of these audits will be brought to the monthly QAPI committee for further education and training opportunities.</p> <p><u>Individual to Ensure Compliance</u> Director of Nursing or Designee will ensure compliance.</p> <p><u>Date of Compliance</u> February 25, 2016</p>		

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F 314	<p>Continued From page 20</p> <p>According to progress notes dated 09/21/15 at 4:13 p.m., "At 7:20 a.m. came in to check his blood sugar resident was on his side... noticed a open area on his left buttock 5.0 x 4.0 (cm-centimeter) oval in shape... also noted right heel red and mushy applied tincture of Benzoin to bilateral heels and floated heels with pillow...". A PU status record dated 09/21/15 identified this PU as "unstageable" and was "80% eschar (dead tissue covering a wound bed)" and 20% granulated wound bed. A physician's note dated 09/22/15 indicated the wound was, "approximately 5 cm x 5 cm... part of the area looks black/dark and is unstageable...".</p> <p>In an interview on 01/14/16 at 8:22 a.m., Staff B (Director of Nursing) stated, "We were surprised when we discovered it (PU to buttock)." Staff B indicated the resident had gone to an appointment three days prior to the discovery of the PU and that the amount of time spent in the wheelchair probably contributed to the development of the PU. In an interview on 01/19/16 at 7:20 a.m., Staff B indicated she would expect staff to identify and report this skin issue prior to it developing into a 4 cm by 5 cm unstageable PU with eschar.</p> <p>Additionally, a Telephone Order, dated 09/21/15, directed staff to "apply Tincture of [redacted] to bilateral heel (every day)" and "float heels" for a "Stage I (PU)." Record review revealed no indication staff measured or monitored Stage I PUs to the heels, nor did staff re-evaluate the effectiveness of this intervention.</p> <p>In an interview on 01/19/16 at 9:36 a.m., Staff H (Nurse Consultant) confirmed Resident #134 had</p>	F 314		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505512</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/19/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GARDEN TERRACE HEALTHCARE CENTER OF FEDERAL WAY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>491 SOUTH 338TH STREET FEDERAL WAY, WA 98003</b>	
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F 314	Continued From page 21 an order that described a Stage I PU to the heel and indicated there should be, but there was no assessment, measurement, care planning or tracking of the heel PU.	F 314		
F 329 SS=E	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to	F 329	<b>F-329-Unnecessary Medications</b>  <u>Individual Residents</u> #279 was assessed with no negative outcome. #294 had Sleep Assessment done, dose reduction was done for [REDACTED] #282, #66 and #124 no longer reside at the facility.  <u>Residents in similar situations</u> Facility will audit all residents who are on medication for insomnia and ensure Sleep Assessments are done, proper non-pharmalogical interventions are put in place for all Insomnia Medications, including PRN Psychotropic Medications.	

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F 329	<p>Continued From page 22</p> <p>ensure three of five residents (#s 279, 294 &amp; 282) reviewed for unnecessary medications and two of two (#s 66 &amp; 124) supplemental residents were free of unnecessary medications related to adequate indications for use, use of non-pharmacological interventions prior to the use of an as needed psychotropic medication, and consistent monitoring of the medication.</p> <p>Findings include:</p> <p><b>RESIDENT #279</b> Record review revealed Resident #279 admitted to the facility after a hospitalization on [REDACTED] 15. She returned to the hospital on [REDACTED] 15 and re-admitted to the facility on [REDACTED] 16.</p> <p>According to hospital notes from the first admission, the hospital discontinued the resident's [REDACTED] and [REDACTED] (both [REDACTED] medications) due to concerns the resident experienced [REDACTED].</p> <p>A hospital note, dated 12/30/15, revealed "Would continue to hold [REDACTED] (concern over [REDACTED] last admission). Starting to get a little tearful, will monitor and may need to restart Rx (prescription)."</p> <p>A psychiatric Advanced Registered Nurse Practitioner note, dated 12/23/15 during the resident's first facility admission, identified the resident had a long history of [REDACTED] but "would like to not start an [REDACTED] at this time. Will continue to monitor and eval for meds if necessary. Recent [REDACTED] at hospital, probable per notes. If in future needs [REDACTED] consider [REDACTED]..." due to history of [REDACTED].</p>	F 329	<p><b>F-329- Unnecessary Medications (Cont.)</b></p> <p><u>Measures to prevent reoccurrence</u> Licensed Nursing Staff will be in-serviced on conducting a Sleep Assessment prior to implementing a medication order for Insomnia. Licensed Nursing Staff will be in-serviced on ensuring that prior to giving a PRN medication for Insomnia or PRN Psychotropic, a non-pharmacological intervention has been attempted and documented.</p> <p><u>On-going Monitoring</u> RCM's will audit residents with hypnotics and PRN psychotropic medications for compliance with documentation, assessments and interventions. Audits will be reviewed by the DON</p>		

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F 329	<p>Continued From page 23 [REDACTED] concern.</p> <p>A progress note, dated 01/12/16, revealed the resident expressed concern "about no longer being on [REDACTED] feels [REDACTED] tired and overall [REDACTED]. MD asked facility to clarify with PCP (primary care physician)." According to a progress note, dated 01/13/16, the resident's "PCP called back and confirmed she was on [REDACTED] XR 225 mg (milligrams) q (every) day. Facility MD ordered it restart at resident's request." On 01/13/16, the physician ordered [REDACTED] XR 225 mg every night.</p> <p>According to Mosby's 2014 Nursing Drug Reference, a potential effect of [REDACTED] is [REDACTED] which is a potentially life threatening drug reaction that occurs when too much [REDACTED] builds up in the body. Symptoms include "increased heart rate, shivering, sweating, dilated pupils, tremors, high blood pressure, hyperthermia, headache, confusion. If these occur, stop product, administer [REDACTED] antagonist if needed...". This guide also indicated the maximum dose of [REDACTED] that could be prescribed was 225 milligrams a day, the dose prescribed to Resident #279.</p> <p>In an interview on 01/14/16 at 1:50 p.m. Resident #279 stated she had been informed she would resume the [REDACTED] that evening. When asked if the physician or facility staff had discussed [REDACTED] its symptoms, her recent diagnosis of it, her increased risk for recurrence given her history, or alternate [REDACTED] options that would not put her at risk for the [REDACTED] she stated none of that had been discussed with her.</p>	F 329	<p><b>F-329- Unnecessary Medications (Cont.)</b></p> <p>and negative findings of these audits will be presented to the monthly QAPI committee x3 months for further education and training opportunities.</p> <p><u>Individual to Ensure Compliance</u> Director of Nursing or Designee will ensure compliance.</p> <p><u>Date of Compliance</u> February 25, 2016</p>	
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F 329	<p>Continued From page 24</p> <p>In an interview on 0/14/16 at 2:07 p.m., Staff F, Resident Care Manager, stated she was not aware the psychiatric ARNP had seen the resident, "It must have been when she was upstairs" (during her first admission). She stated the facility physician requested she ask the resident's primary care physician what the resident had been on in the past and what had been effective. Staff F acknowledged the PCP had not been provided with recent information regarding the resident's experience with [REDACTED]. She also stated she had not spoken to the resident about specifics related to her risk for [REDACTED] nor was any specific information about what to monitor for placed in the care plan or Medication Administration Record (MAR).</p> <p>In an interview on 01/15/16 at 8:15 a.m., Staff F stated the physician discontinued the [REDACTED] and started [REDACTED] which did not have the same risk for [REDACTED]. She acknowledged as the information about the resident's experience was in her record numerous times, it should have been considered before the physician ordered the medication. Failure to ensure proper medication selection and prescribing placed this resident at risk for adverse results from a medication.</p> <p><b>FACILITY POLICY</b> According to the 06/10 facility Sedative/Hypnotics policy and procedure, "Prior to ordering a sedative/hypnotic drug, a comprehensive sleep evaluation must be completed. The drug should be the last resort rather than the first thing tried... Sedative/hypnotic drugs can be considered unnecessary if no attempt has been made to determine and correct the reason for the</p>	F 329		

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F 329	<p>Continued From page 25</p> <p>inappropriate sleep pattern... If a resident is admitted with sedative/hypnotic medication, complete a sleep evaluation, using MED-PASS Form MP -5486 on admission, and track for three days... Attempt usage of non-pharmaceutical interventions, such as providing a quiet environment, reducing noise, offering a bedtime snack, etc."</p> <p>RESIDENT #294 Resident #294 admitted to the facility on [REDACTED] 16 following a hospitalization. Admission orders included [REDACTED] 5 mg, give one tablet at bedtime [REDACTED] as needed (prn).</p> <p>Record review revealed a 01/09/16 Social Services note that the resident "states she takes [REDACTED] prn at home an understands the risks with this medication. She chooses not to make any changes at this time. She demonstrates no ASE (adverse side effects) with use of medications. Will continue to monitor." There was no sleep assessment in the record determining which, if any, non drug interventions had been attempted in the past, how frequently the resident used the medication or the resident's goal regarding the use of the medication.</p> <p>In an interview on 01/14/16 at 2:30 p.m. Staff L said for residents who received hypnotics, the staff monitored hours of sleep, but the facility did not have a formal sleep assessment. In addition, Staff L said the nursing staff were to follow the insomnia behavior plan and document non drug interventions on the behavior monitor.</p> <p>The 01/05/16 Psychotropic Medication Care Plan related to [REDACTED] use listed interventions including "Attempt non-medication interventions."</p>	F 329		

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F 329	<p>Continued From page 26</p> <p>The Resident's January 2016 behavior plan for [REDACTED] instructed staff to assess and treat for pain and ensure comfort.</p> <p>Review of the January 2016 MAR revealed the [REDACTED] was administered on 01/05 at an undocumented time, 01/06 at 9:00 p.m., 01/07 at 9:00 p.m., 01/09 at 8:30 p.m., 01/10 at 11:50 p.m., and 01/11 at 10:00 p.m.</p> <p>Review of the Behavior/Intervention Monthly Flow Record revealed no documented interventions to promote sleep from 01/0 through 01/13/16. Additionally, review of the progress notes revealed no non drug interventions were attempted prior to administration of the prn [REDACTED]. For example on 01/09/16 at 10:14 p.m., "Request [REDACTED] for [REDACTED] as ordered."</p> <p>In addition, staff documented concomitant administration of the prn [REDACTED] with the prn pain medication [REDACTED] on 01/08/16 at 9:00 p.m. and 01/12/16 at 9:00 p.m. The associated progress note dated 01/12/16 at 9:44 p.m. stated, "Medicated x 1 with pain meds, positive relief. Requested sleeping pill due to insomnia." Concomitant administration of both medications left the facility unable to accurately determine which medication was effective.</p> <p>In an interview on 01/14/16 at 2:39 p.m. Staff C said prior to administering prn [REDACTED] staff were instructed to offer redirection or snacks and ensure pain was controlled. They were to document those interventions on the behavior flow sheet. When asked about a sleep assessment, Staff C said "I talked to her (today) and she said she takes [REDACTED] at home, 15 tablets a month, cut in half (2.5 mg) and here she</p>	F 329		
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F 329	<p>Continued From page 27</p> <p>is getting 5 mg." Staff C said the resident told her she took the medication because "she worries, lays down and gets to worrying and then can't sleep and in the morning is not nice to her family." Staff C said she called the doctor and received an order to decrease the dose of the medication to match what the resident had taken prior to admission to the facility.</p> <p>Failure to conduct a sleep assessment prior to initiating the prn [REDACTED] contributed to the resident receiving a higher dose than necessary which constituted an unnecessary medication. In addition, failure of the facility to attempt non drug interventions prior to administration and concomitant administration with pain medications placed the resident at risk to receive an unnecessary medication.</p> <p>RESIDENT #282 Resident #282 admitted to the facility on [REDACTED] 16 with post surgical care needs. Record review revealed Resident #282 received as needed [REDACTED] (a [REDACTED] medication) on 01/06, 07, 08, 10, 12 &amp; 13/16 for complaints of insomnia without benefit of non-drug interventions prior to it's administration.</p> <p>Progress notes dated 01/11/16 at 11:48 p.m. indicated the resident was, "given [REDACTED] to help with sleep" but there was no indication facility staff attempted to determine what caused the difficulty sleeping or what non-drug interventions were attempted prior to the administration of the sedative medication.</p> <p>Record review revealed no assessment of the resident's insomnia, what her normal sleep patterns were, how long she usually slept, or any</p>	F 329			

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F 329	<p>Continued From page 28</p> <p>measurable goals regarding the use of the sleep medication.</p> <p>In an interview on 01/14/16 at 10:34 a.m., Staff E (Resident Care Manager) indicated that on admission staff obtain a signed consent form and the resident was informed about "side effects and stuff." Staff E indicated that nursing did not perform any formal sleep assessment and that Social Services evaluated the use of psychotropic medications.</p> <p>In an interview on 01/14/16 at 10:46 a.m. Staff L (Social Services) indicated Resident #282 was started on this medication in the hospital and there was no assessment of the resident's sleep patterns, including if the resident experienced a problem falling or staying asleep.</p> <p>In an interview on 01/14/16 at 10:19 a.m., Staff I (Licensed Nurse) stated, "Staff are monitoring her sleep." Staff I further indicated the resident liked her room to be dark and that staff should document interventions such as offering fluids or making sure the room was dark in the progress notes. Record review revealed no non-drug interventions prior to the administration of the as needed sleeping medication.</p> <p>In an interview on 01/13/16 at 8:56 a.m., Resident #282 stated, "I wasn't sleeping real well, it's too hot for me in here, last night they got me a fan." The resident also stated, "No I don't have a hard time sleeping at home, I have a fan at home all the time." The resident reiterated the temperature had impacted her ability to sleep. The resident elaborated, "...I sleep five or six hours a night... when I am at home I normally go to bed at 2:00 or 3:00 in the morning... sometimes I would sleep</p>	F 329			

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F 329	<p>Continued From page 29 until 10:00 a.m...". Failure to assess the etiology of and provide non-drug interventions for insomnia constituted the use of an unnecessary drug.</p> <p><b>RESIDENT #66</b> Similar findings were noted for Resident #66 for whom staff administered prn [REDACTED] on 09/29/15 at 11:00 p.m. and 10/08/15 at 9:00 p.m. with no non drug interventions and no sleep assessment.</p> <p><b>RESIDENT #124</b> Resident #124 was in the facility from [REDACTED] through [REDACTED] 15 for a short term rehab stay after hospitalization following a [REDACTED]</p> <p>Admission orders included [REDACTED] 12.5 mg prn, 1 time a day as needed for agitation. According to the 07/20/15 Psychotropic Medication care plan, staff were to "rule out treatable medical causes for behaviors that are disturbing resident and others or interfering with care and attempt non-medication interventions."</p> <p>Review of the July 2015 MAR revealed the [REDACTED] was administered 07/24/15 at 1:00 a.m. concomitantly with prn Tylenol. According to the progress note dated 07/24/15 at 4:52 a.m., "Medicated with prn [REDACTED] 12.5 mg and prn Tylenol 650 mg for increased agitation and left hip pain with relief. Slept for about 5 hours on the couch. Adjusting well to the unit. Will monitor."</p> <p>Further review revealed the prn [REDACTED] was administered 07/26/15 at 4:50 p.m. Review of the Behavior/Intervention Monthly Flow Record revealed no non drug interventions were attempted prior to the administration of the anti-psychotic medication. The 07/26/15 8:49</p>	F 329		

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F 329	Continued From page 30 p.m. progress note stated "Resident (family member) here resident upset twisting her arm, prn [REDACTED] given with no results."  In an interview on 01/19/16 at 9:26 a.m. Staff D stated staff were expected to attempt non drug interventions, listed on the care plan, prior to administration of prn psychotropic medications. Staff D indicated staff should document interventions attempted on the behavior monitor and in the progress notes. When asked regarding concomitant use with pain medications, Staff D said staff should evaluate for signs/symptoms of pain and rule out pain first.	F 329		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure a system in which resident's records were complete,	F 514	<b>F-514</b>  <u>Individual Residents</u>  Resident #134 and #277 no longer reside at the facility. #288 Care Directive and Care Plan were updated pertaining to her dentures, #288 INR was checked and WNL, #282, #61 and #63 records were reviewed. No further action to those records.	

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505512	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  01/19/2016
NAME OF PROVIDER OR SUPPLIER  GARDEN TERRACE HEALTHCARE CENTER OF FEDERAL WAY			STREET ADDRESS, CITY, STATE, ZIP CODE 491 SOUTH 338TH STREET FEDERAL WAY, WA 98003	
(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 514	<p>Continued From page 31</p> <p>accurate and accessible. Failure to ensure records: accurately reflected care provided and/or resident condition; were legible; and/or accurately reflected allergies and preferences placed residents at risk for unmet needs.</p> <p>Findings include:</p> <p>Refer to CFR 483.20(b)(xii), Comprehensive Assessment, F-272 CFR 483.20(k)(2), Comprehensive Care Plan, F-279</p> <p>RESIDENT #134 Resident #134 was seen at a wound clinic on 12/17/15 related to an unstageable pressure ulcer on his buttock. Documents related to this consult, including any assessments or recommendations, were not available in the resident's record. In an interview on 01/19/16 at 9:45 a.m., Staff H (Nurse Consultant) indicated they should have been included in the resident's medical record stating, "I am not sure why they weren't in the record."</p> <p>Additionally, record review revealed Resident #134 utilized a urinary catheter. Review of RITA (computerized Nursing Assistant documentation program) records revealed Resident #134 was incontinent of urine. In an interview on 01/19/16 at 7:20 a.m., Staff B was asked to provide information regarding why the catheter leaked and why a catheterized resident would require prompted voiding, as indicated in RITA. Staff B later responded there was no indication the catheter leaked (and was thus the resident was not incontinent of urine) and the RITA documentation was "probably inaccurate".</p>	F 514	<p><b>F-514 (Cont.)</b></p> <p><u>Residents in similar situations</u> Audit resident records who go to the Wound Clinic to ensure Visit Notes are in chart when patient returns, audit Soft Care II (prior RITA) for BM's, incontinence and showers for accuracy. Dietary Manager will audit resident Food Preferences and ensure that the TRAYS System is updated accurately with resident's likes and dislikes, as well as Food Allergies.</p> <p><u>Measures to prevent reoccurrence</u> Licensed Staff will be in-serviced by DNS or Designee on proper documentation on Medical Records, Soft Care ADL accuracy and BM monitoring.</p>	

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F 514	<p>Continued From page 32</p> <p>Review of Medication Administration Records (MARs) for 09/15 and 10/15 revealed staff consistently wrote over previous entries for bowel monitoring, making the documentation difficult to read. Similarly, in the Diabetic Administration Records (DARs) for 09/15, staff wrote over previous entries for blood sugar (BS) results or sites on 09/24, 09/26 and 09/27/15, making the entries illegible. Failure to ensure documentation was clear prevented staff from ensuring appropriate doses were administered.</p> <p>RESIDENT #288 Resident #288 admitted to the facility on [REDACTED] 16 with multiple medically complex diagnoses. According to an oral assessment form dated 01/04/16 and Care Directives dated 01/05/16, Resident #288 had upper and lower dentures.</p> <p>Observation with Staff E on 01/19/16 at 8:15 a.m. confirmed the resident had multiple broken/carious teeth including: two on the lower left jaw, one on the lower right, one on the upper left and two on the upper right. Staff E confirmed the resident had multiple intact teeth and was not utilizing dentures. Failure to ensure aide directives were correct detracted from staff's ability to provide adequate care.</p> <p>Additionally, review of MARs revealed staff documented they administered one 2.5 milligram (mg) tablet of [REDACTED] and one 1.0 mg tablet of [REDACTED] each day from 01/04/16 through 01/17/16. Review of remaining medications and Emergency Kit medication dispensing records revealed that two 1.0 mg of [REDACTED] remained in bingo packs that were not administered. Staff E, on the morning of 01/19/16, stated it appeared that staff documented the administration of these</p>	F 514	<p><b>F-514 (Cont.)</b></p> <p>Executive Director or designee will in-service Dietary Manager on ensuring that the Food Preference Form is done on admission and updated accordingly and to ensure that resident's likes, dislikes and food allergies are listed on TRAYS System Cards accurately.</p> <p><u>On-going Monitoring</u> Staff Development and or MDS will monitor Soft Care (previous RITA) for the accuracy of ADL's and BM documentation. Registered Dietician or designee will audit TRAYS System for food allergies and likes and dislikes weekly x 4 weeks and monthly x 3 months. Negative findings of these audits will be brought to the monthly QAPI committee for further education and training opportunities.</p>	

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F 514	<p>Continued From page 33 medications but they were not administered.</p> <p><b>RESIDENT #282</b> Review of Resident #282's DARs revealed that on 01/05, 06, 07, 08 and 11/16 facility staff either wrote the incorrect dose of [REDACTED] for the BS documented or wrote over previous entries, making the entries illegible. Similar findings were identified for Resident #282's pain assessments and bowel entries where staff wrote over previous entries making the documentation illegible. Additionally, RITA documentation regarding bowels did not reflect nursing documentation of bowels. According to MARs, Resident #282 had a Bowel Movement (BM) on 01/11/16 which was not reflected in the RITA system. In an interview on the morning of 01/19/16, Staff B indicated these records should match.</p> <p><b>RESIDENT #61</b> Similar findings were identified for Resident #61 for whom staff wrote over a previous entry on the Bowel Monitor on the evening shift of 12/03, 04, 10 13, 14, 15, 19, 20, 21, 22, 23, 24, 25, 29, 30 and 31/15. Some of the entries were difficult to decipher, while on 12/20/15, the entry was completely illegible.</p> <p><b>RESIDENT #63</b> Similar findings were identified for Resident #63 for whom the 01/03 and 04/16 entries on the Bowl Monitor were illegible due to the original entry being written over. Several other days in the month were difficult to decipher as well.</p> <p>In an interview on 01/15/16 at 8:42 a.m., Staff F stated if staff needed to change an entry, they were to circle the original entry and make a note on the back of the form. She acknowledged many</p>	F 514	<p><b>F-514 (Cont.)</b></p> <p><u>Individual to Ensure Compliance</u> Director of Nursing or Designee will ensure compliance.</p> <p><u>Date of Compliance</u> February 25, 2016</p>	
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F 514	<p>Continued From page 34 entries were difficult or impossible to decipher.</p> <p><b>RESIDENT #185</b> In an interview on 01/15/16 at 10:37 a.m., Staff D explained if a resident received a sponge bath, nursing assistants documented it in the computer (RITA) and not on paper, however bed baths and showers were written on the paper shower sheets and then transferred into RITA.</p> <p>Review of paper shower records for Resident #185 revealed she received a bed bath or shower on 01/04 and 07/16, however review of RITA records revealed there was no indication the resident received either a bed bath or shower on 01/04 or 07/16.</p> <p>In addition, staff frequently scribbled out or marked over entries on the Shower Record in the Tulip unit, making many entries illegible.</p> <p>In an interview on 01/19/16 at 8:49 a.m., Staff D stated RITA and the paper shower sheets should match for bed baths or showers given. In addition, she stated the nursing assistants needed some training on not scribbling out an entry, making it illegible.</p> <p><b>RESIDENT #277</b> A nutrition assessment dated 12/31/15 indicated the resident reported that gluten caused the resident to experience flatulence. Dietary communication documents dated 12/31/15 revealed staff identified Resident #277, "prefers gluten free bread, noodles, and cereal." A telephone order dated 12/31/15 directed staff to change the resident's diet to a regular with gluten free bread, noodles and cereal per resident preference. Review of the dietary card revealed</p>	F 514		

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F 514	<p>Continued From page 35</p> <p>the resident "disliked" bread/toast, pancakes, waffles and french toast. Failure to ensure tray cards accurately reflected the resident's preferences (gluten free bread/pasta products) rather than omitting bread products put the resident at risk for unmet preferences.</p> <p>RESIDENT #75 Observation of the lunch meal on 01/11/16 at 12:33 p.m. revealed Resident #75 had eaten half of her salad for lunch. In an interview at that time the resident stated, "It's way too much for me to eat, besides, I am allergic to eggs so I can't eat those." There were two boiled eggs cut in half noted on the resident's salad.</p> <p>Record review revealed eggs were listed on the allergy sticker on the inside of the chart and listed by dietary as an allergy but, "eggs ok in baked foods." Review of the tray card revealed no indication staff were aware of the egg allergy. Failure to ensure tray cards accurately reflected assessments placed the resident at risk to experience negative reactions related to food allergies.</p>	F 514			



ADDA Aging & Disability Services Administration

AGING AND DISABILITY SERVICES ADMINISTRATION  
**Nursing Home Survey Report**  
 STATE AND CORRESPONDING FEDERAL REQUIREMENTS

1. Page <u>1</u> of <u>1</u> Pages
2. DATES OF DATA COLLECTION <b>01/11, 12, 13, 14, 15 &amp; 19/2016</b>
5. TIME OF SURVEY <input checked="" type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Weekend <input type="checkbox"/> Holiday
7. LICENSE NUMBER <b>1350</b>

3. NAME OF FACILITY  
**Garden Terrace Alzheimer's Center of Excellence**

4. TYPE OF SURVEY  
 Full  Post  Complaint  Other, specify \_\_\_\_\_

6. STREET ADDRESS CITY STATE ZIP CODE  
**491 S 338<sup>th</sup> St Federal Way WA 98003**

**NOTE: According to RCW 18.51.060, the Department is authorized to deny, suspend or revoke a license and/or assess monetary fines for deficiencies cited in this report.**

8.	9. WASHINGTON ADMINISTRATIVE CODES 388-97	10. CODE OF FEDERAL REGULATION 42 CFR 483.	11. FEDERAL DATA TAG NUMBER	12. REPEAT DEFICIENCY FROM SURVEY DATED	13. NEW CITATION ON POST SURVEY	14. LICENSEE'S PLANNED DATE OF CORRECTION
<input checked="" type="checkbox"/> The requirements of the following WAC's and corresponding CFR's were not met. The text of the statements of deficiencies and the licensee's plan of correction may be read on CMS form 2567, dated: <u>01/19/2016</u> .  **Licensee must complete column 14.  <input type="checkbox"/> The following deficiencies were determined to be corrected.	-1000(2)(c)(i)(k)(l)	20(b)(1)(iii), (iv), (xi), (xii)	272		<input type="checkbox"/>	
	-1020(1), (2)(a)	20(k)	279	11/14	<input type="checkbox"/>	
	-1060(1)	25	309	11/14, 01/14, 09/12, 08/14, 09/10	<input type="checkbox"/>	
	-1060(3)(b)	25(e)	314	11/14	<input type="checkbox"/>	
	-1060(3)(k)(i)	25(l)(1)	329		<input type="checkbox"/>	
	-1720(1)(a)(i) - (iii)	75(l)(1)(ii)(iii)	514	01/14	<input type="checkbox"/>	
						<input type="checkbox"/>

15. SURVEYOR'S SIGNATURE(S)			
SIGNATURE	DATE <u>03/02/16</u>	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE
16. LICENSEE OR AGENT			
SIGNATURE OF LICENSEE (OR AGENT)		TITLE <u>Executive Director</u>	DATE <u>3/3/16</u>



AGING AND DISABILITY SERVICES ADMINISTRATION  
**Nursing Home Survey Report**  
 STATE AND CORRESPONDING FEDERAL REQUIREMENTS

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5. TIME OF SURVEY <input checked="" type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Weekend <input type="checkbox"/> Holiday
7. LICENSE NUMBER 1350

3. NAME OF FACILITY <b>Garden Terrace Alzheimer's Center of Excellence</b>	4. TYPE OF SURVEY <input checked="" type="checkbox"/> Full <input type="checkbox"/> Post <input type="checkbox"/> Complaint <input type="checkbox"/> Other: specify _____
6. STREET ADDRESS <b>491 S 338<sup>th</sup> St.</b>	CITY STATE ZIP CODE <b>Federal Way WA 98003</b>

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	-1060(3)(k)(i)	25(l)(1)	329		<input type="checkbox"/>	
	-1720(1)(a)(i) - (iii)	75(l)(1)(i)(ii)(iii)	514	01/14	<input type="checkbox"/>	
						<input type="checkbox"/>

**15. SURVEYOR'S SIGNATURE(S)**

SIGNATURE 	DATE 03/02/16	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

**16. LICENSEE OR AGENT**

SIGNATURE OF LICENSEE (OR AGENT)	TITLE	DATE
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