

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505096</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/10/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>TOPPENISH NURSING &amp; REHAB CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>802 WEST THIRD STREET TOPPENISH, WA 98948</b>		
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>This report is the result of an unannounced Off-Hours Quality Indicator Survey conducted at Toppenish Nursing &amp; Rehabilitation Center on 01/02/14, 01/03/14, 01/06/14, 01/07/14, 01/08/14, 01/09/14, and 01/10/14. The survey included data collection on 01/08/14 from 7:30 p.m. to 10:30 p.m. A sample of 35 residents was selected from a census of 61. The sample included 30 current residents, the records of 5 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>Refugia S. Botello, R.N. Lucy Fromherz, R.N. Hermelinda Thompson, R.N. Liisa Johnson, R.N.</p> <p>The survey team is from:</p> <p>Department of Social &amp; Health Services Aging and Long-Term Support Administration Residential Care Services, District 1, Unit C 3611 River Road, Suite #200 Yakima, Washington 98902</p> <p>Telephone: (509) 225-2800 Fax: (509) 574-5597</p> <p><i>[Signature]</i> Residential Care Services Date 483.10(e), 483.75(l)(4) PERSONAL</p>	F 000	<p>Received Yakima RCS <b>FEB - 3 2014</b></p> <p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, <b>Toppenish Nursing and Rehabilitation Center</b> does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p>		
F 164				F 164	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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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OMB NO. 0938-0391

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F 164 SS=E	<p>Continued From page 1</p> <p><b>PRIVACY/CONFIDENTIALITY OF RECORDS</b></p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility: 1) failed to ensure the privacy and confidentiality of resident clinical records and/or personal medical information for 7 of 35 stage 2 sampled residents (#s 7, 19, 59, 26, 41, 2 &amp; 96); and 2) failed to ensure the personal privacy</p>	F 164	<p><b><u>F-164</u></b></p> <p>The facility has provided education to nursing staff as it relates to the protection of residents clinical information.</p> <p>The facility provided education on privacy with nursing staff during procedures and treatments.</p> <p>RCM/designee will perform rounds to ensure that confidentiality of clinical information and resident privacy is maintained during procedures and treatments.</p> <p>The above remedies will be completed by 02/28/14.</p> <p>Director of Nursing/designee to ensure correction.</p>	<p><u>3/7/14</u> <u>02/28/14</u></p>

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F 164	<p>Continued From page 2</p> <p>was maintained for 5 of 12 residents (#s 17, 96, 26, 41 &amp; 101) observed during medication administration. The failed practice created the potential for a negative effect on residents' psychosocial well-being related to the need for privacy. Findings include:</p> <p><b>PRIVATE INFORMATION</b></p> <p>On 01/02/14 at 12:54 p.m. Resident #7's diabetic flow sheet was visible to anyone in the hallway on an unattended medication cart in the west hall. The information visible included the resident's blood glucose results, insulin administration, and diagnoses.</p> <p>On 01/03/14 at 10:49 a.m. Resident #19's Treatment Record was visible on an unattended treatment cart in the west hall. The information visible included treatment orders and the resident's diagnoses.</p> <p>On 01/03/14 at 12:55 p.m. Resident #59's Medication Administration Record (MAR) was visible on an unattended medication cart in the west hall. The information visible included medication orders and the resident's diagnoses.</p> <p>On 01/03/14 at 1:13 p.m. Resident #26's MAR was visible on an unattended medication cart in the west hall. The information visible included medication orders and the resident's diagnoses.</p> <p>On 01/07/14 at 5:15 p.m. Resident #41's MAR was visible on an unattended medication cart in the west hall. The information visible included the medication the resident received as well as his diagnoses.</p> <p>On 01/08/14 at 11:45 a.m. a "Resident Bowel</p>	F 164		

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F 164	<p>Continued From page 3</p> <p>Management Report" was visible on an unattended medication cart in the west hall. The report included information regarding recent bowel movements and laxative requirements for Residents #s 26, 19, and 2.</p> <p>On 01/08/14 at 11:55 a.m. a sheet of paper was on an unattended medication cart on the west hall that included information regarding medication for Residents #96 and #7's blood glucose results.</p> <p>On 01/09/14 at 3:26 p.m. Resident #96's MAR was visible on an unattended medication cart in the west hall. The information visible included medication orders and the resident's diagnoses.</p> <p>Review of the facility admission packet revealed the following: the Resident's Rights document included the statement residents have the right "to have clinical and personal records kept confidential." The corporate Notice of Privacy Practices included the following statement: "We are required by law to maintain the privacy and security of your protected health information</p> <p><b>ROOM PRIVACY</b> On 01/08/14 at 12:23 p.m. during the medication observation, Staff Member D, a Licensed Nurse (LN), entered Resident #17's room to use the sink in the adjacent bathroom to wash her hands. When the LN entered the room, she did not knock or address the resident who was sitting in her wheelchair across the room.</p> <p>On 01/09/14 at 4:45 p.m. during a medication administration, Staff Member K, a LN, entered Resident #96's room without knocking on the door or announcing herself. The resident was in his bed near the window, when the LN arrived at</p>	F 164		

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F 164	<p>Continued From page 4</p> <p>the bed she stated "hi [Resident name], here are your meds."</p> <p>On 01/09/14 at approximately 3:00 p.m. Staff Member A, the Director of Nursing, stated they did not have a specific policy regarding providing residents privacy during cares, it is "just expected." She provided a "Licensed Nurse Competency" form as an example of what was expected. The form included the following statement: "Nurse provides privacy (closes doors, windows, curtain, etc.) and explains procedure."</p> <p><b>BODY PRIVACY</b></p> <p>On 01/08/14 at 3:08 p.m. during the medication observation, Staff Member N, a LN, entered Resident #26's room and checked his blood sugar level that included sticking his finger with a lancet. The door was open to the hallway, the privacy curtain was not pulled, and the resident was visible from hallway. Resident #26 was not interviewable. During the same medication pass observation, at 3:40 p.m. Staff Member N checked Resident #41's blood sugar with the door and privacy curtain open and the resident was visible from the hallway.</p> <p>On 01/09/14 at 12:03 p.m. Staff Member O, a LN, entered Resident #101's room. He was sitting in a chair next to his bed nearest the door and was visible from the hallway. The resident indicated he wanted his insulin injection in his abdomen. The LN assisted the resident to pull up his shirt and gave the injection of insulin in his abdomen. The privacy curtain was not pulled and the door was open and the resident's uncovered abdomen</p>	F 164		

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F 164	Continued From page 5 was visible from the hallway during the injection.  On 01/10/14 at 12:30 p.m. Staff Member A, stated that she expected the nursing staff to provide residents with privacy by not leaving confidential resident information visible on the medication or treatment carts. She stated she expected the nursing staff to knock on the door prior to entering a resident's room and provide privacy by either closing the door or pulling the privacy curtain during procedures. Further she stated that would include finger sticks for blood glucose checks and subcutaneous (under the skin) injections.	F 164		
F 172 SS=F	483.10(j)(1)&(2) RIGHT TO/FACILITY PROVISION OF VISITOR ACCESS  The resident has the right and the facility must provide immediate access to any resident by the following:  Any representative of the Secretary;  Any representative of the State;  The resident's individual physician;  The State long term care ombudsman (established under section 307 (a)(12) of the Older Americans Act of 1965);  The agency responsible for the protection and advocacy system for developmentally disabled individuals (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act);  The agency responsible for the protection and	F 172	<b>F-172</b>  Residents have been informed of the visiting hours guidelines. A visiting hour's statement has been posted at each nurse's station.  All staff has been in-serviced on the visiting hour guidelines.  The admission packet has been modified to include admission hour guidelines.  FC - Glenda Valenzuela - corporate - Visiting Hours 7 - 9 PM special circumstances will be addressed with family/ resident's Responsible person to ensure	3/7/14 02/28/14

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F 172	<p>Continued From page 6</p> <p>advocacy system for mentally ill individuals (established under the Protection and Advocacy for Mentally Ill Individuals Act);</p> <p>Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and</p> <p>Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident.</p> <p>The facility must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the residents' right to 24-hour visiting access by immediate family or other relatives for 2 of 19 residents (#97, 105) interviewed and 1 of 3 resident's (#95) family members interviewed during stage 1. The denial of visitors prevented the residents from celebrating New Year's with their friends and family. Findings include:</p> <p>On 01/03/2014 at 9:50 a.m. two family members of Resident #95 stated the facility had visiting hours and 8:00 p.m. was the "cut off time" and they could not visit after 8:00 p.m.</p> <p>On 01/03/14 at 12:25 p.m. Resident #105 stated the facility had visiting hours and was told by one</p>	F 172		

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F 172	<p>Continued From page 7</p> <p>of the nurses that "the staff don't like people coming in and out after 9:00 p.m." Further, she stated "my husband wanted to visit late on New Year's Eve; however, the nurse on duty was not sure if he could come, so he just stayed home."</p> <p>On 01/03/14 at 2:20 p.m. Resident #97 stated that "when the doors get locked at night, no one can have visitors." He was told this by staff on New Year's Eve.</p> <p>On 01/07/14 at 4:40 p.m. Staff Member B, a Resident Care Manager, stated "the doors are locked at 8:00 p.m. for security reasons. There is a door bell for visitors to use to be let in by staff." Further, she stated there were no restrictions to having visitors after 8:00 p.m.</p> <p>On 01/08/14 the front/main doors were observed locked at 9:00 p.m.</p> <p>On 01/09/14 at 11:20 a.m. Staff Member C, a Resident Care Manager and Staff Member G, the Social Service Director stated the facility had visiting hours. Residents cannot have visitors outside visiting hours unless there is prior approval. The doors are locked sometime between 8-9:00 p.m. at night and unlocked in the morning. We tell families with extenuating circumstances that the administrator would give authorization for them to be here later at night.</p> <p>On 01/09/14 at 1:30 p.m. Staff Member A, the Director of Nursing, stated that families can visit any time, even after the doors are locked, they just need to ring the doorbell. She stated she explained this information during the resident's admission to the facility, but maybe residents and families think since the doors are locked, no one</p>	F 172		

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F 172	Continued From page 8 can visit.	F 172			
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.  The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).  The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.  The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	<b>F-225</b> Resident #7 and #28 had further investigation and comprehensive fall assessments completed. Additional care plan interventions have been initiated based on assessment data with goal to minimize fall risk factors. Care plans have been developed for resident #7 and #28 with interventions to minimize risks of injuries.  Residents #97 and #32 had investigations completed into allegations that were reported. Incident reports have been filed with reporting to state agency.		

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This REQUIREMENT is not met as evidenced by:  
Based on observation, interview and record review, the facility failed to ensure it thoroughly investigated, documented, and reported incidents according to CFR 483.13(c)(2)(3)(4) involving 4 of 5 sampled residents (#28, 32, 97, and 7) reviewed for incidents/accidents. This placed residents at risk of abuse and neglect due to lack of a thorough investigation to determine the cause. Additionally, the facility failed to report alleged mistreatment to the State Agency. Findings include, but are not limited to:

Resident #7. When interviewed on 01/07/14 at 3:25 p.m., He was unable to answer questions due to his inability to speak. He was seated in the hallway in his tilt-in-space wheelchair that allowed the back of the chair to recline, preventing him from falling forward out of the chair. Due to [REDACTED]

[REDACTED]

The 08/23/13 comprehensive assessment identified his need for extensive assistance of two caregivers for transferring the resident to and from his wheelchair.

The current care plan identified a fall risk [REDACTED]

[REDACTED] The staff approaches were to tilt his wheelchair into an upright position when the

F 225

Staff received education on investigation requirements for incidents along with requirements for individual and facility reporting.

Administer/Director of Nursing to review incidents and allegations to ensure timely and thorough investigations are completed and to ensure mandatory reporting requirements are complied with.

The above remedies will be completed by 02/28/14

Administrator/Director of Nursing responsible to ensure correction.

3/7/14  
~~02/28/14~~

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F 225	<p>Continued From page 10</p> <p>resident was at the dining room table and tilt the wheelchair back when resident was away from the table. The later approach was to avoid him losing his balance and falling forward.</p> <p>Review of the incident dated 12/11/13 noted Staff Member D, a Licensed Nurse (LN), following the facility's procedure, had completed the investigation report. Documentation included that following the resident transfer by two nursing assistants using a mechanical lift, the resident was transferred into his wheelchair located in his room. After unhooking the sling from the lift, the second nursing assistant started to leave the room when the resident's wheelchair flipped over backwards landing on it's handle bars. After the nursing assistants sat the wheelchair back in the upright position, it flipped a second time. The licensed nurse was notified and assessed the resident who did not hit his head because of the handlebars. When the resident attempted to grab the mechanical lift as he was falling, it caused his forearm to scrape up against the armrest resulting in a large bruise with three skin tears. The wheelchair was given to physical therapy to be fitted with an anti tip bar.</p> <p>However, no further investigation was completed as to why the wheelchair had tipped on these occasions when it had not tipped before when he was transferred. Without locating the cause of the incident by completing a thorough investigation, the resident(s) were at risk of further injuries as the facility could not determine whether the staff were negligent, did not follow the care plan, and/or required training.</p> <p>Resident #28, diagnoses include: [REDACTED]</p>	F 225		

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F 225	<p>Continued From page 11</p>  <p>On 01/07/14 at approximately 1:30 p.m. Staff Member R, a LN, stated "I was here when he leaned on the adjoining bathroom door and fell, and we were lucky he did not have an injury, the door is supposed to be closed but must have been left open."</p> <p>On 01/07/14 at 2:25 p.m. observed the bathroom door to the adjoining room was open. When Staff Member S, a Nursing Assistant (NA), was asked about the open door she stated "the resident in the adjoining room is a 2 person assist so I know it was not the resident who left the bathroom door open, it is our responsibility to make sure it is always closed."</p> <p>On 01/07/14 at 2:30 pm Staff Members S, a NA, stated "He falls because he uses a reacher, he takes his roommate's reacher and turns off his bathroom alarm so when he turns off the alarm we have no way of knowing he is in the bathroom." She added "when I have found him in his bathroom I notice he tends to lock only one of the brakes on his wheelchair so when he gets up, his wheelchair shifts away from him." She also mentioned she has told nursing staff of her concerns.</p> <p>Record review revealed a total of 15 falls in the past 6 months (May 2013 through December 2013); 13 of the falls were in his bathroom. 7 of the 12 investigation reports were not comprehensive and did not identify the multiple</p>	F 225		

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F 225	<p>Continued From page 12</p> <p>factors contributing to his falls such as: placement of the wheelchair and/or whether the resident's wheelchair brakes were engaged, or use of the roommate's reacher to turn off the bathroom door alarm.</p> <p>On 01/07/14 at approximately 3:00 p.m. Staff Member A, the Director of Nurses (DNS), stated she was not aware the resident was turning off the bathroom door alarm, the resident was locking only one of the brakes on his wheelchair while he was in the bathroom, nor that staff were consistently closing the bathroom door to the adjoining room. She added "I own this."</p> <p>On 01/07/14 at approximately 1:00 p.m. an incident dated 09/02/13 included the resident was found sitting on the bathroom floor at 8:40 a.m. the fall resulted from a self transfer from the toilet seat to his wheelchair and the "toilet seat riser stuck to the resident then slipped/fell making the resident slip onto bathroom floor." The resident sustained a 2 centimeter diameter bump to his back.</p> <p>On 01/07/14 at approximately 1:30 p.m. Staff Member R, a LN, stated "I think the toilet riser is too high for him." She added he has had two different toilet risers but not did recall dates as to when the toilet riser had been placed.</p> <p>On 01/08/14 at 3:30 p.m Staff Member C, a LN, stated the previous and current riser in the resident's bathroom which had contributed to his falls had not been assessed for proper fit. She added "I spoke with the Occupational Therapist and she would not have recommended to have placed the current riser in his bathroom. We will be getting an assessment today."</p>	F 225		

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F 225	<p>Continued From page 13</p> <p>The lack of a comprehensive investigation allowed the resident to continue to fall and sustain injuries.</p> <p>Resident #97. Admitted to the facility on [REDACTED] with a diagnosis that included anxiety. The admission comprehensive assessment dated 11/19/13 revealed the resident had no mental impairment, no mood or behavior problems.</p> <p>On 01/03/14 at 2:30 p.m. Resident #97 stated that he had been verbally abused by two NAs. He stated it occurred about a month ago and he believed the incident was reported to the Administrator by his representative.</p> <p>On 01/06/14 a review of the facilities State Agency Reporting Log did not include any abuse incidents for Resident #97.</p> <p>On 01/09/14 at 11:25 a.m. Staff Member C, a Resident Care Manager, stated she was aware that Resident #97 had alleged he was verbally abused by two nursing assistants a few weeks ago. She believed there was an incident report and an investigation.</p> <p>On 01/09/14 at 11:30 a.m. Staff Member G, the Social Services Director, stated the incident was reported to her and she talked to the resident, a witness and the staff involved; however, she could not find her documentation and added "I must not have documented it."</p> <p>Review of Resident #97's progress notes with Staff Member G revealed a progress note written by Staff Member R, a LN, dated 12/05/13 regarding the incident described by the Resident</p>	F 225			

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F 225	<p>Continued From page 14</p> <p>#97. No further documentation could be found in the medical record.</p> <p>On 01/09/14 at 1:30 p.m. the DNS stated she was not aware that Resident #97 had alleged being verbally abused by staff.</p> <p>On 01/09/14 at 2:00 p.m. Staff Member U, the Administrator, stated Resident #97's representative contacted him several weeks ago and reported the incident to him. The Administrator stated he did not document his conversation with the representative, completed an investigation or report the alleged verbal abuse to the State Hotline.</p> <p>Resident #32. The comprehensive assessment dated 01/02/14 identified her as cognitively intact. There was no documentation of the alleged incidents in the facility State Agency incident log. When interviewed, Staff Member A discussed what she had observed about the alleged abuse.</p> <p>On 01/02/14 at approximately 3:11 p.m. Resident #32 stated that she was "out of it" when she was admitted and she felt that the nursing assistants were talking to her in an abusive way. She stated she could not recall the names of the nursing assistants that allegedly verbally abused her. She stated that she reported the incident to the DNS.</p> <p>On 01/07/14 at 12:15 p.m., Staff Member I, a NA, stated that Resident #32 has made many allegations of abuse in the past. She also stated that Resident #32 usually reports that staff was twisting her body or pushing her certain ways while they were providing care. She then</p>	F 225			

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F 225	<p>Continued From page 15</p> <p>explained that a "buddy system" had been implemented and stated that two staff were always supposed to enter the room together when providing care. Staff Member I stated that there are times that one staff member will go in to the room to give the resident food, knowing there was a second staff member in the hallway.</p> <p>On 01/08/14 at 12:17 p.m., Staff Member M, a Physical Therapist, stated that Resident #32 has complained of staff not doing the proper positioning that she had been taught in Occupational and Physical Therapy. He stated that he has demonstrated training with the nursing assistants on how to properly assist resident with mobility.</p> <p>On 01/08/14 at 3:25 p.m., Staff Member A, the DNS, stated that Resident #32 was "rough on staff" when she first came in and "down right mean." She stated she observed the alleged incident and explained that she was standing outside the resident's open door, due to the resident not wanting staff to close the door. Staff Member A stated the nursing assistants were trying to transfer her from the wheelchair to the bed and the resident was "doing gyrations with her body." Staff Member A stated that the resident had said the staff were hurting her, and was calling staff profanities. The staff asked the resident to stop moving and she continued to scream profanities, and the staff was able to eventually lay her down.</p> <p>Staff Member A stated the particular incident was not abuse and that it was the only allegation that "has been reported" by Resident #32.</p> <p>Staff Member A stated the staff had worked with</p>	F 225			

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F 225	Continued From page 16 the resident's facility physician due to the resident being "horrible." Staff Member A defined "horrible" as profanity words being used all the time, for example, "you do not know your (expletive) job." She stated that Resident #32 was vulgar with her words with staff and there were times that staff were coming out of the room in tears. Staff Member A stated that she met with the resident daily to provide one-on-one care and just take time to talk with her and that it was very time consuming. Staff Member A stated the physician tried some medications. She further discussed that the resident was cruel to night shift.	F 225		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure 1 of 8 residents (#60) with urine collection bags was covered to maintain resident dignity. Failure to consistently cover the urine collection bag had the potential to negatively impact the residents' quality of life.	F 241	<b><u>F-241</u></b>  Resident #60 had his catheter collection bag covered to maintain dignity and privacy.	

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F 241	<p>Continued From page 17 Findings include:</p> <p>Resident #60. The resident had a diagnosis of neurogenic bladder (lacks bladder control). According to a comprehensive assessment, dated 11/17/13, the resident was cognitively intact with minimal depression. He also required extensive assistance for activities of daily living and had [REDACTED]</p> <p>On 01/09/14 at 10:48 a.m. Resident #60 was observed in the front entrance of the facility with a urine collection bag was hanging off the left side of his electric chair, the collected urine was visible to residents and visitors. Nursing assistants and licensed, nursing staff were observed to pass the resident in hall without noticing the uncovered catheter bag. At 11:06 a.m. Resident #60 was observed talking to Staff Member C, a Residential Care Manager, at the North nurses station and the uncovered bag was visible.</p> <p>On 01/09/14 at 11:40 a.m. Staff Member C stated all catheter collection bags should be covered and in the privacy bags. The privacy bags were available in the supply room to the nursing staff.</p> <p>On 01/09/14 at 11:55 a.m. Resident #60 was observed in his room. When asked regarding to his uncovered urine collection bag, the resident stated "the girls could not find the blue cover for my cath bag this morning, so I just went without it." Further he said he was not bothered by others seeing his urine and stated "I am used to it."</p> <p>On 01/09/14 at 12:10 p.m. Staff Member V, a Nursing Assistant, stated she helped get Resident #60 up out of bed around 10:00 a.m. that morning</p>	F 241	<p>Residents who have urine collection bags have been reviewed and received collection bag covers as indicated.</p> <p>Nursing staff has been educated on dignity of the resident as it applies to urine collection bags.</p> <p>Shift rounds completed by Charge Licensed Nurse/Resident Care Manager to ensure resident privacy is maintained.</p> <p>The above remedies will be completed by 02/28/14.</p> <p>Director of Nursing/designee responsible to ensure correction.</p>	<p>3/7/14 02/28/14</p>

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F 241	Continued From page 18 and could not find the privacy cover for his catheter bag.	F 241		
F 250 SS=D	<p>Review of care plan dated 01/16/12 for indwelling urinary catheter included the approach to "store collection bag inside a protective dignity pouch."</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure medically related social services were provided for 1 of 1 (#19) residents reviewed for end of life and bariatric issues. This placed the resident at risk of unmet psychosocial needs with a potential to improve her health and wellbeing. Findings include but are not limited to:</p> <p>Resident #19. Admitted on [REDACTED] following a hospitalization since 03/2013. Diagnoses included [REDACTED]</p> <p>She was again hospitalized and re-admitted to the nursing home on [REDACTED]. The 'history and physical' documented she did not use the physician ordered C-PAP (continuous positive</p>	F 250	<p><b><u>F-250</u></b></p> <p>Resident #19, Care plan reviewed. Psychologist in place, to meet with resident one time weekly and as needed.</p> <p>Staff and in-room care plan have been updated with approaches and interaction/socialization to meet resident needs.</p>	

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F 250	<p>Continued From page 19 airway pressure) machine at night because she "feels scared" with it covering her nose/mouth with a mask.</p> <p>On [REDACTED] she was admitted to an out of the area hospital's intensive care unit (ICU). Two hospital summaries documented her admittance was for respiratory failure and medically complex heart disease. A concern was noted by the physician that she continually had refused to wear her C-PAP machine at night for the breathing assistance that was needed to obtain enough oxygen.</p> <p>The physician further documented the resident understood she was currently not a bariatric surgery candidate as she would need to be healthier to undergo surgery. Therefore, there was no cure for her current condition. Further, she was not happy to move back to the nursing home in Toppenish but realized it was her only option. "Although tearful about not being a bariatric surgery candidate, this may change if she continued to lose weight and improved her health." She appeared "incredibly tearful and withdrawn...", but she did weigh 50 pounds less than previous admission in March. While the physician discussed her medical condition and goals with her, she stated she "wanted to live." The physician recommendations upon discharge included assist in weight loss and mental health counseling.</p> <p>The 09/18/13 plan of care identified "mental health involvement to be considered as appropriate." Mood and behavior issues were depression and anxiety, and continual "crying, sobbing, tearfulness, etc." Interventions included "She likes to converse, provide her with</p>	F 250	<p>Resident similar situation, Care plans and interventions have been reviewed and updated.</p> <p>Social Service Director to assess and interview as indicated by residents need. Will review Care plans and update per MDS cycle and as needed.</p> <p>Remedies will be completed by 02/28/14</p> <p>Director of Nursing /designee responsible to ensure correction.</p>	<p>3/7/14 02/28/14</p>
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F 250	<p>Continued From page 20</p> <p>conversation as time allows but be mindful of time constraints and professional topics of discussion." Use of distraction tools, encourage daily activities, avoiding napping, and teaching relaxation techniques (which were without specific instructions for staff knowledge). Under 'Discharge Planning' dated 11/19/13 it was identified "she has a life expectancy of 6 months or less to live" related to her medical conditions. However, end-of- life was not addressed on the plan of care to support the resident during this time period.</p> <p>On 01/02/14, the resident was eating in the dining room at a table alone. She initiated a conversation about wanting to return to the Seattle area where she had lived most of her life. She said when she had been to a hospital in that area in December, she felt like she was home and hated to return to the nursing home.</p> <p>On 01/07/14 at approximately 12:30 p.m., Staff Member G, the Social Service Director, stated she usually covers terminal care with dignity such as keeping a resident comfortable at all times, offering a chaplain, but she had not put it in the care plan for Resident #19. She had tried to offer a mental health professional but the resident's pay source did not allow. Staff Member G did "touch base" with her especially in the dining room. The resident had anxiety and depression, she needed someone to talk with and vent her frustrations. She wanted to live back in the Seattle area, but there was not a nursing home that would accept her there. She did use a "smart phone" to keep in touch with family, but that was lost at the hospital. She had been "disconnected" without the phone and her "facebook" account. When asked about the care</p>	F 250			

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F 250	<p>Continued From page 21</p> <p>plan intervention of conversing with the resident as "time allows but be mindful of time constraints and professional topics of discussion." Staff Member G stated the resident liked to talk and this approach was not meant to sound as it did.</p> <p>On 01/07/14 at approximately 3:00 p.m., Staff Member A, the Director of Nursing, stated the resident was only up for lunch or an activity. She agreed the resident needed support to encourage weight loss and for the possibility of dying from her health condition.</p> <p>On 01/08/14 at 11:45 a.m. the resident was lying in bed with her head of the bed raised. She stated she did want to lose weight but did not think she was on a special type of diet. She said she could die next week because her heart and lungs were so bad. She did not want to die. She would like to have the bariatric surgery, but she knew she had to lose weight and get healthier before she could have it. She would like support from the staff to help with weight loss, "no one really discussed or supported it; they only asked about what kind of foods I liked or disliked." When asked about her fear of dying, she said she was fearful and that no one was talking with her about that, either. She said she did get up for lunch usually or if she wanted to attend an activity, like movie and popcorn. Her exercises were not being done regularly and consisted of the arm and leg while in bed. She said she would welcome help with her weight loss.</p> <p>Although there were psychosocial needs identified of depression and anxiety, there was a lack of individualized interventions developed for staff support. The resident expressed her possible death due to her condition but that she</p>	F 250			

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F 250	Continued From page 22 wanted to live. She had expressed her fear of the C-PAP therapy that assisted in preventing hypoxia. She expressed her wish to lose weight so she could undergo a bariatric surgery. However, medically related social services failed to address these issues with an individualized plan that would allow her to obtain specific goals.	F 250		
F 252 SS=D	483.15(h)(1) <b>SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</b>  The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.  This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide a home like environment for 2 of 28 resident's (#95 & 104) rooms observed for home like environment during stage 1. This failure had the potential to lessen the quality of life for the residents residing in the facility. Findings include:  Resident #104. Admitted on [redacted] with diagnoses to include [redacted]. The comprehensive assessment dated 12/31/13 indicated the resident had problems with memory and decision making.  From 01/02/14 through 01/10/14, Resident #104's room was noted to have bare walls with no colors or decorations to create a home-like environment.  On 01/10/14 at approximately 1:20 p.m. Staff	F 252	<b>F-252</b>  Room 45A has been converted to temporary storage for an ongoing remodel project. Resident 104 was interviewed and the room decorated to meet his preference of Western art.  This deficiency will be corrected in a remodel project that started January 27, 2014 and will conclude by March 31, 2014. Rooms are receiving new flooring, sink, mirror, lighting and wardrobe.  The Maintenance Director will include homelike environment in his monthly room inspection task which is tracked and documented in our automated TELS task tracking system. An email is sent to the Administrator if a TELS task is missed. <i>Corporate nurse consultant</i>	
		<i>2/11/14 RB</i>	<i>Resident # 95 - decorations placed on walls to create homelike environment. Administrator responsible to ensure correction</i>	

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F 252	Continued From page 23 Member G, the Social Services Director, while standing in Resident #104's room was asked if she felt the room was a homelike environment. She stated, "no, it is not a home-like environment." When asked who was responsible for ensuring a homelike environment, she stated "the administrator or activities."  Resident #95. Admitted to the facility with diagnoses that included [REDACTED]. The 11/14/13 comprehensive assessment indicated it was "very important" to the resident to care for his personal belongings.  From 01/02/14 through 01/10/14 Resident #95's room was noted to have bare walls with no home like decorations.  On 01/10/14 at 1:05 p.m. Resident #95's representative stated the resident had been in facility for two months and did not feel like it bothered resident not to have his walls decorated, but stated "It would be nice to see that."  On 01/10/14 at approximately 1:30 p.m. Staff Member W, the Activity Director, while standing in Resident #95's room was asked if she felt the room displayed a homelike environment, she stated, "no." When asked who was responsible for ensuring resident rooms had a homelike environment, she stated "we are all responsible, we usually discuss new residents moving in at stand up meetings."	F 252			
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED  The assessment must accurately reflect the	F 278			

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F 278	Continued From page 24 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 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.  Clinical disagreement does not constitute a material and false statement.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to complete an accurate comprehensive assessment for 2 of 4 sampled residents (#28, 56) reviewed for falls and activities of daily living. This placed them at risk for unmet needs. Findings include:  Resident #28 diagnoses included; [REDACTED]	F 278	<u>F-278</u>  Resident #28 and #56 have had coding inaccuracies corrected.  Staff member C in-serviced on accuracy and correct coding at time error was discovered.  Staff member C will attend MDS 3.0 training on February 11 and 12 of 2014.  MDS accuracy will be monitored per utilization review as indicated and after each MDS assessment.  The above remedies will be completed by 02/28/14.  Director of Nursing/designee responsible to ensure correction. TC [REDACTED] Corporate Nurse Consultant MDS modifiers were promised 2/7/14	3/7/14 02/28/14

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F 278

Continued From page 25



Record review revealed incident investigation reports for 15 falls between May 2013 thru December 1, 2013.

Record review revealed the resident's quarterly comprehensive assessment (MDS) dated [REDACTED] coded the resident as not having falls yet he fell on 05/27/13 and 06/04/13; The quarterly comprehensive assessment (MDS) dated [REDACTED] documented he had zero falls during the assessment period, yet he experienced 7 nonjury falls. Also, the falls with injuries was left blank yet he had a fall on 07/03/13 with bruising and swelling to the right foot. The Annual comprehensive assessment (MDS) dated [REDACTED] coded one fall with no injury, yet he experienced two falls (09/27/13 and 11/09/13).

On 01/07/14 at approximately 4:10 p.m. Staff Member C, a Licensed Nurse (LN), stated the reason for the inaccurate coding of the residents' comprehensive assessments were due to her misunderstanding about the look back period, "I was only looking at a 7 day look back period for all of the assessments."

(Note: The instructions for coding the falls on the assessments reads to code any falls since admission/entry or reentry or prior assessment, whichever is more recent.)

Resident #56. Diagnoses included senile dementia.

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F 278	<p>Continued From page 26</p> <p>Record review revealed an annual comprehensive assessment dated 10/14/13. Section G Functional Status which coded both sections bed mobility and dressing as limited assist for self-performance a decline of her functional status compared to the previous quarterly assessment dated 07/14/13 in which the resident had been coded as independent with bed mobility and dressing.</p> <p>On 01/09/14 at approximately 10:00 a.m. Staff Member C, a LN, stated the resident had not declined in either the bed mobility or the dressing with self-performance. " The coding on the assessment was wrong. I use the information from the nursing assistants (NA) to code the resident 's functional status. She added the NA who had been "writing down the resident's self-performance did not understand the definitions of limited assist versus independent."</p> <p>On 01/08/13 at 9:45 p.m. Staff Member Z and Staff Member AA, both NAs stated the resident was independent with bed mobility and "was able to move around bed, in and out and turning without a problem." Both stated the only assistance she needed was help with tying her shoe laces and fastening the back of her bra and added "we have been doing this for a long time it is not a new need." Staff Member Z added, "I have been assisting the resident with tying her shoes laces and fastening her bra ever since I started working in this nursing home, about seven months ago."</p> <p>On 01/09/14 at 10:15 a.m. the resident was in bed and observed to independently transfer in and out of bed without any help.</p>	F 278		

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<p>F 279</p> <p>F 279</p> <p>SS=D</p>	<p>Continued From page 27</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to assess and develop a plan of care for 1 of 1 resident (#19) reviewed for end of life palliative/hospice care. This placed the resident at risk of unmet needs. Findings include:</p> <p>Resident #19. Admitted on [REDACTED] with diagnoses of [REDACTED]. The hospital documentation noted she was tearful and withdrawn; realized there was no cure to her current condition. The hospital's Palliative Care</p>	<p>F 279</p> <p>F 279</p>	<p><b>F-279</b></p> <p>Resident #19 comprehensive care plan has been updated to describe the services to attain and maintain her highest physical, mental and psychosocial well being. Measureable goals and objectives have been initiated to support end of life services.</p> <p>Resident with similar concerns have had care plans audited to ensure approaches are in place to address mental, physical and psychosocial needs.</p> <p>Care plans will be reviewed and updated in MACC meeting and with MDS assessment cycle.</p> <p>The above remedies will be completed by 02/28/14.</p> <p>Director of Nursing/designee to ensure correction.</p>	<p>3/7/14</p> <p>02/28/14</p>

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F 279	<p>Continued From page 28</p> <p>consultant had addressed comfort care with the resident.</p> <p>There was a comprehensive assessment for a significant change of condition on 12/21/13. The prognosis question regarding a life expectancy of less than 6 months was documented as 'yes.'</p> <p>The 09/18/13 care plan did not identify the need for and develop interventions for the end-of-life support identified in the comprehensive assessment. The discharge plan was updated on 11/19/13 for a life expectancy of 6 months or less related to severe pulmonary disease and congestive heart failure. However there were no interventions developed that would assist the resident at the end-stage of her life.</p> <p>On 01/07/14, the resident stated she was aware she could die soon because of her health condition, but she did not want to die.</p> <p>When interviewed on 01/07/14 at approximately 12:30 p.m., Staff Member G, the Social Service Director, stated she had not developed or implemented end-of-life approaches for the resident. Thus, there was no development for services to attain the resident's highest mental and psychosocial well-being during this mentally distressing time period in her life.</p>	F 279		
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p>	F 323		

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F 323	<p>Continued From page 29</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure the environment remained free of accidental hazards for 2 of 3 residents (#28,7) reviewed for falls. Failure to keep the environment free of accidents hazards placed the residents at risk for further falls and/or injury. Findings include:</p> <p>Resident #28. Diagnoses included [REDACTED]</p> <p>Record review of an incident report dated 09/02/13 revealed the resident was found sitting on the bathroom floor at 8:40 a.m. The fall resulted from a self transfer from toilet seat to his wheelchair and the "toilet seat riser stuck to the resident then slipped/fell making the resident slip onto bathroom." The resident sustained a 2 centimeter diameter bump to his back.</p> <p>On 01/07/14 at approximately 1:30 p.m. Staff Member R, a Licensed Nurse (LN), stated "I think the toilet riser is too high for him."</p> <p>On 01/08/14 at 3:30 p.m. Staff Member C, a LN, stated the previous and current toilet seat riser in the resident's bathroom which had contributed to his falls had not been assessed for a proper fit. She added she spoke with Staff Member T, the Occupational Therapist and "she would not have</p>	F 323	<p><u>F -323</u></p> <p>Resident #28, the toilet seat riser used by resident #28 was removed from the resident's bathroom. The resident was accessed for the proper size riser and a locking riser was put in place.</p> <p>The Maintenance Director has been in-serviced to discard all non-locking risers and to order only locking risers in the future. The Licensed nurse staff has been in-serviced that all toilet risers must be assessed for the proper fit prior to installation.</p> <p>Signs have been placed on bathroom doors of resident #28, instructing NAC's to assure the door is secure before providing cares.</p> <p>The Maintenance Director will include testing riser security and inspecting for door closure signs in his monthly room inspection task which is tracked and documented in our automated TELS task tracking system. An email is sent to the Administrator if a TELS task is missed.</p>	

*2/11/14 RB Date of correction 2/28/14 Resident #7 - w4 - ongoing daily rounds by RN/MP*

*2/11/14 RB - [REDACTED] - [REDACTED] - [REDACTED] - [REDACTED]*

*disagree to ensure that residents are free from elevated equipment and environment hazards. DNS - responsible for ensuring corrections.*

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F 323	<p>Continued From page 30</p> <p>recommended to have placed the current riser in his bathroom, we will be getting an assessment today."</p> <p>Review of an incident dated 07/03/13 revealed the resident was found on the bathroom floor. The report noted the base of the resident's toilet was leaking water "likely a bad seal" caused the resident to slip and fall.</p> <p>On 01/07/14 at approximately 1:30 p.m Staff Member R, a LN, stated "i was here when he leaned on the adjoining bathroom door and fell, we were lucky he did not have an injury, the door is supposed to be closed but must have been left open."</p> <p>On 01/07/14 at 2:25 p.m. it was observed the bathroom door to the adjoining room was open. When Staff Member S, a NA, was asked about the open door she stated "the resident in the adjoining room is a 2 person assist, so I know it was not the resident who left the bathroom door open. It is our responsibility to make sure it is always closed."</p> <p>The lack of maintaining the resident's bathroom free of environmental hazards allowed the resident to continue to fall.</p> <p>Resident #7. The 08/23/13 comprehensive assessment identified a change in condition following the resident's [REDACTED] He was also identified at risk for falls with a history of falls from his bed.</p> <p>The updated care plan identified his risks for falls related [REDACTED]</p>	F 323	<p>Resident #7 wheelchair was placed in a slightly tilted position to prevent falling forward out of his chair. Staff was educated on care plan intervention to ensure that resident's wheelchair is tilted when he is not eating.</p>	
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F 323	<p>Continued From page 31</p> <p>██████████ The interventions included tilting the wheelchair when he was up but position it upright when at the dining room table. The plan also addressed his impaired mobility with the intervention again documented for a tilt-in-space wheelchair that was to be tilted when up to prevent the resident from loosing balance and falling forward - tilt into an upright position when at table and tilt the wheelchair back when the resident was away from table.</p> <p>When interviewed on 01/07/14 at 3:25 p.m., the resident nodded his head that his wheelchair had fallen backwards to the floor while he was sitting in it. (This caused a bruise and skin tears.) He was unable to speak to answer further questions ██████████ His wheelchair was in an upright position; not tilted. ██████████</p> <p>When interviewed on 01/07/14 at 4:00 p.m., Staff Member F, a LN, stated the wheelchair was a tilt-in-space model. She demonstrated that it should have been put into a slight recline position which prevented the resident from falling forward and out of the chair. However, it had been in an upright postion prior to her tilting it backward.</p> <p>When interviewed on 01/07/14 at 4:10 p.m., Staff Member H, a NA, stated she had been told that when he was up in his wheelchair, he should be tilted back to avoid falls.</p> <p>On 01/08/14 at approximately 10:00 a.m., the resident was seated by the central nursing station in his wheelchair. The chair was noted in an upright position without any recline. Staff Member E, a LN, walking in the hall nearby, was</p>	F 323		
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F 323	Continued From page 32 asked if his chair was in a tilted position. She said no, she would recline it, but as she walked toward the resident, he suddenly lunged forward with his head towards his knees. She called his name and rushed to tip the chair back into a tilted position. She stated the tilt was necessary to prevent him from falling forward and out of the chair.  On 01/08/14 at 2:45 p.m., the resident was seated outside of the dining room, leaning slightly forward in the wheelchair. The wheelchair was in a full upright position. Staff Member C, a LN, stated the chair was upright and tilted it into a reclining. She stated when he fell asleep in the chair, he could fall forward.  On 01/08/14 at 10:15 a.m., the Physical Therapist stated the reason for the resident's wheelchair to tilted back was because he tended to fall asleep when sitting up and then leaned forward which would cause a forward fall [REDACTED]  However, the resident's wheelchair had not been consistently tilted/reclined per the care plan directives as observed on 01/07/14 and 01/08/14, even after it was brought to the attention of the staff by the surveyor.	F 323		
F 329 SS=E	483.25(l) 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	F 329		

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F 329	<p>Continued From page 33</p> <p>adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to monitor duplicate therapy medications for potential side effects for 1 of 5 residents (#42) reviewed for unnecessary medications. The lack of monitoring placed the resident at risk for health complications that could be serious and/or life threatening when similar medications were given in conjunction with each other. Further, the facility failed to ensure Gradual Dose Reductions (GDR) were completed in a timely manner for 4 of 5 residents (#28,42,51,58) reviewed for unnecessary medications. This placed the residents at risk of taking medications which were not needed and/or at the lowest possible dose that would still provide efficacy of the medication. Lastly, the facility failed to consistently monitor the effectiveness of pain medications for 1 of 2</p>	F 329	<p><u>F-329</u></p> <p>Residents #28, 42, 51 and 58 have had medication reviews completed to assess that medications are necessary to treat specific conditions. Additionally gradual dose reduction requirements reviewed with MD interventions in place to ensure that all elements of medication therapy are in compliance with accepted standards. Risks and benefits of medications reviewed with residents.</p> <p>Residents receiving psychoactive medications have had reviews completed to determine that all elements of use are in place.</p> <p>Resident #97 had a comprehensive pain assessment completed to ensure effectiveness of current pain medicine regime. Medication Account Record (MAR) in place to document and assess pre/post pain levels.</p> <p>Residents receiving pain medications have had reviews completed to determine all elements of use are in place.</p> <p>Resident #42 has had a pharmacy review completed of medications to assess for duplicate therapy. MD has</p>		

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Continued From page 34  
residents (#97) reviewed for pain. This failure placed the resident at risk for undetermined efficacy and adverse consequences related to potentially unnecessary medication use. Findings include:

**DUPLICATE THERAPY**  
Resident #42. Admitted on [REDACTED] with diagnoses of [REDACTED]. She received [REDACTED] for her [REDACTED]. She was also receiving [REDACTED]. Further, she received [REDACTED].

When the facility pharmacist was interviewed by phone on 01/08/14 at 2:15 p.m., he stated the [REDACTED]. "As the resident now had high, but not too very high triglycerides, the medications were working." The contraindications for the duplicate medications "can outweigh the risk for these two" (although there was no documentation by the doctor or the facility in the resident's record of risk and benefit). He noted the serious complication that could be considered life threatening would be rhabdomyolysis (damaged skeletal muscle tissue breaks down and the products released into the bloodstream can lead to kidney failure). The staff should be looking for symptoms of severe muscle pain and dark urine.

The 11/12/13 annual comprehensive assessment evaluated the resident was cognitively intact and had no indicators of psychosis, hallucinations, or

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been contacted with recommendations.  
Licensed nurse staff educated on documentation and assessment requirements for pain medication administration.

Licensed nurse staff educated on requirements to assess and monitor for adverse side effects of resident medication therapy.

Pharmacist will continue to complete monthly reviews on residents medication therapy and ensure that all aspects of use for residents medications have justifications and diagnosis in place.

Psychotropic Medication Review meeting is conducted monthly with Pharmacist and Interdisciplinary Team (IDT). Residents on psychoactive medications will have comprehensive reviews completed to ensure medications remain necessary to treat specific conditions. Dosage reductions, care plans, ASE's will be reviewed at this time to determine that all elements of psychoactive medication use is in place.

Remedies to be completed by 02/28/14.

3/7/14  
02/28/14

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F 329	<p>Continued From page 35 delusions.</p> <p>Although there was a psychotropic drug consent form signed on 11/08/13 which included risks and benefits of the medications, there was no such form for the two cholesterol medications with potential serious side effects.</p> <p>On 01/06/14 at approximately 4:00 p.m., Staff Member F, a Licensed Nurse (LN), stated when the cholesterol medications were first started, the cholesterol level was in around 1100s and was now down in the 300s. She stated she had monitored for stomach upset with these two medications, but "that was about all."</p> <p>On 01/09/14 at 11:45 a.m., Staff Member E, a LN, stated the physician should have considered risk and benefits of the two cholesterol medications although there was no 'risk and benefit' documented. She was unaware of the side effects of the cholesterol medications and what side effects were to be monitored.</p> <p><b>GRADUAL DOSE REDUCTION</b> Resident #42. The 'Note to Attending Physician' from the pharmacy consultant dated 09/25/13 revealed a recommendation for the physician to review the need for [REDACTED]. The last GDR was noted to have been attempted on 09/20/12. The CMS (center for medicare services) guidelines for GDRs were documented for the physician to review which included the need for annual attempts. However, the physician responded with a discontinuation of another medication, [REDACTED] as the resident was no longer using it, but did not address the others listed above.</p>	F 329	Director of Nursing/designee to ensure correction.	
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F 329	<p>Continued From page 36</p> <p>The 12/06/13 annual psychotropic drug assessment revealed the [REDACTED]</p> <p>[REDACTED] The indicators/behaviors included worrying, depression, hallucinations, paranoia. She had received psychoactive drugs on a long-term basis which the resident stated had helped control her mood swings. She was to continue her regimen of psychotropic medication and "no dose reductions are planned at this time."</p> <p>When the facility pharmacist was interviewed by phone on 01/08/14 at 2:15 p.m., Further, there were four medications on the list sent to the physician that were to treat depression or were antipsychotic medications. A GDR was recommended but the pharmacist was not aware if there was an attempted GDR after his letter to the doctor. He stated for a GDR, each medication would be tapered at different times, not all together in order to determine the outcome of the lowered dose for each medication.</p> <p>On 01/08/14, Staff Member B, a Resident Care Manager, reviewed the record for a GDR for 2013. She also reviewed the documented Psychotropic Drug Assessment dated 12/06/13. It noted the resident had received psychoactive drugs on long term basis. According to Staff Member B the resident had no psychotropic medication dose reductions planned.</p> <p>The resident's care plan noted there was a "failed dose reduction" while in the hospital. There was a decrease in the [REDACTED] dosage by the hospitalist. However, the resident was in the hospital for a period of three days and the medications were lowered at the same time, thus</p>	F 329		

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F 329	<p>Continued From page 37</p> <p>not meeting the pharmacist acknowledged requirements for a GDR.</p> <p>Resident #58. Diagnosed with a depressive disorder.</p> <p>Record review revealed a physician order for [REDACTED] to be administered daily with a start date of 06/29/11. Review of the October, November, and December 2013 Medication Administration Records revealed the medication had been administered on a daily basis. The Psychoactive Drug reviews dated 4/27/13, 7/24/13, and 10/23/13 and the social worker's quarterly review dated 11/01/13 did not contain any evidence of a gradual dose reduction (GDR). The psychoactive medication facility policy clearly included the facility would follow the federal recommendations for gradual dose reductions for psychoactive drugs.</p> <p>On 01/09/14 at approximately 12:50 p.m. Staff Member A, the Director of Nurses (DNS), stated there were no documented evidence a GDR had been attempted for this resident. She added "it is necessary to complete GDRs."</p> <p>Resident #51. Diagnoses that included non-organic psychosis, dementia, anxiety, and depression.</p> <p>Observation of the resident during the survey he alternated between sleeping while sitting in his wheelchair in the south hallway, and speaking with nursing staff, and/or people watching.</p> <p>Record review revealed a physician order for [REDACTED] one in the evening</p>	F 329		

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F 329	<p>Continued From page 38 for anxiety with a start date of 04/23/12 and [REDACTED] at bedtime for sleep disturbance, with a start date of 10/24/12.</p> <p>On 01/09/14 at 3:25 p.m. Staff Member B, a LN, stated "the GDR for [REDACTED] had not been done for this resident."</p> <p>On 01/09/14 at approximately 3:20 p.m. Staff Member G, the Social Services Director, stated the GDRs for [REDACTED] had not been done. She added sometimes we send out "GDR requests to the doctors but we do not get responses." When asked if she was the person responsible to assure the GDRs were to be done for the residents on psychoactive drugs, she responded with a "yes."</p> <p>Record review with Staff Memembr G revealed a physician's order for [REDACTED] for insomnia. The 2013 October, November, and December "Resident Behavior Report Sheets" read "behavior to look for (document below) ...."Insomnia." Staff Member G stated she had not included on the behavior flow sheet to monitor the resident's sleep pattern, therefore, it had not been done.</p> <p>Resident #28. diagnosed with [REDACTED]</p> <p>Record review revealed the following physician's order for: [REDACTED] daily for depression and [REDACTED] mg at bedtime. Both medications had start dates of 07/03/12 open ended. [REDACTED] 10 mg at 4 pm and 5 mg in the morning with start date of 08/13/12. There was no documented</p>	F 329		
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F 329	<p>Continued From page 39</p> <p>evidence of the facility staff requesting a GDR for the anti-depressant medication or the anti-psychotic medication.</p> <p>On 01/08/14 at 2:30 p.m. Staff Member G, stated the facility does not have the documented requests for the GDR "because they (referring to primary care providers) just do not respond."</p> <p><b>MEDICATION EFFECTIVENESS</b> Resident #97. Admitted to the facility on [REDACTED] with diagnoses including [REDACTED]. [REDACTED] The comprehensive assessment dated 11/19/13 indicated the resident frequently had pain that he rated at 9 of 10 (with 10 being highest) due to healing surgical wounds.</p> <p>On 01/03/2014 at 2:30 p.m. the resident stated he experienced pain with no relief, "I hurt all over, all of the time."</p> <p>On 01/07/14 at 3:45 p.m. the resident was in bed and tearful, his lunch tray was on the bed side table, nothing eaten, he stated he could not eat a thing, he hurt too much.</p> <p>Review of his medical record included a care plan dated 11/23/13 for acute pain related to multiple surgeries, [REDACTED]. [REDACTED] The plan goal was for the resident to "verbalize relief of pain." To achieve this goal, the approaches listed were: 1) administer medication per MD order, evaluate/record/report effectiveness and any adverse side effects; 2) assess effects of pain on the resident (disturbances in sleep, activity, self-care, appetite, psychosocial, etc.); 3) evaluate</p>	F 329		

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F 329	<p>Continued From page 40</p> <p>effectiveness of pain management interventions and adjust if ineffective or adverse side effects emerge.</p> <p>Review of the January 2014 physician orders and Medication Administration Record (MAR) revealed the resident received routine pain medication as follows: [REDACTED] three times a day for pain, Tylenol 1000 mg every 8 hours and [REDACTED] four times a day. The resident also had current orders for [REDACTED] four times a day as needed for pain. Additionally, Resident #97 had an order dated 11/19/13 for [REDACTED] 4-8 mg every 4 hours for pain, this order was discontinued on 12/19/13.</p> <p>Review of the December 2013 MAR revealed the resident received [REDACTED] 8 mg 41 times for pain between 12/01/13 and 12/19/13. The results of the pain medications were not documented on the MAR or progress notes 21 times.</p> <p>Review of the December 2013 MAR and January 2014 MAR revealed the resident received [REDACTED] "as needed" 32 times between 12/24/13 and 01/08/14. The results of the pain medications were not documented on the MAR or progress notes 7 times.</p> <p>On 01/09/14 at 12:00 p.m. Staff Member A, the Director of Nursing, stated there was no formal pain monitor for the effectiveness of routine pain medication. A resident's pain and relief was documented in the MAR when the nurse administers a prn (as needed) medication for pain. The nurses were to document the resident's pain rating from 1 to 10 before and about 30 to 60 minutes after the resident received</p>	F 329		

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F 329  F 332 SS=E	<p>Continued From page 41 the medication. "I expect it (documentation) every time."</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the medication error rate was less than 5%. Medication pass was observed on different shifts and with different licensed nurses; 26 medications were observed and 4 errors occurred when medications were administered to Residents #57 and #96. The medication error rate was 15.3%. Findings include:</p> <p>Resident #57. Admitted on [REDACTED] with diagnoses to include dementia. Review of the comprehensive assessment dated 11/17/13 revealed the resident had highly impaired vision. Review of the resident's care plan dated 05/24/13 revealed he had impaired vision in his left eye related [REDACTED]. [REDACTED] The care plan approach for nurses included "Meds per MD order."</p> <p>On 01/08/14 at 3:30 p.m. during medication observation, Staff Member N, a Licensed Nurse (LN), gave Resident #57 the following medications: Artificial tears in his left eye followed by [REDACTED] in his left eye. The LN</p>	F 329  F 332	<p><u>F-332</u></p> <p>Resident #57 and #96 have had assessments completed. No negative outcomes. MD notified of findings.</p> <p>Licensed nurse staff educated on medication administration procedure and medication error prevention.</p> <p>Medication pass audits completed for staff members D, K and A.</p> <p>Consultant Pharmacy Registered Nurse/Director of Nursing to complete quarterly medication administration audits on Licensed nurse staff to ensure medication error rate is maintained at less than 5%.</p> <p>Remedies to be completed by 02/28/14</p>	<p>3/7/14 02/28/14</p>

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F 332	<p>Continued From page 42</p> <p>stated the resident was [REDACTED]</p> <p>Review of January 2014 physician orders and Medication Administration Record revealed the following: an order dated 06/06/13 for Artificial tears 1-2 drops to the right eye three times a day for dry eyes and an order dated 12/06/13 for [REDACTED] to the left eye three times a day [REDACTED]</p> <p>On 01/09/14 at 12:21 p.m. Staff Member D, a LN, stated she gave Resident #57 his "tears" in both eyes and the [REDACTED] in his left eye. (Different from previous observation and physician orders.)</p> <p>On 01/10/14 at 12:30 p.m. Staff Member A, the Director of Nursing, was informed of the discrepancy between the physician's orders and the LNs not administering eye drops as ordered.</p> <p>On 01/09/14 at 3:35 p.m., Staff Member K, a LN, was observed preparing medications for Resident #96. She poured Medpass (protein shake supplement) half full in a 5 ounce cup (approximately 74 cubic centimeters). She then appropriately measured and poured Miralax (a laxative) powder into a different 5 ounce cup. Lastly, she appropriately measured Metamucil (a bulk-forming fiber laxative) powder and poured it into the cup containing the Miralax. Staff Member K then filled the 5 ounce cup that contained the two powdered medications with water; she then dumped some of the medication and water mixture out into a second 5 ounce cup and filled both cups with water. As Staff Member K brought the medications to Resident #96, he asked "Why do I get two cups of orange drink today?" Staff</p>	F 332	Director of Nursing/designee to ensure corrections.	

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F 332	<p>Continued From page 43</p> <p>Member K stated, "Because you need to drink more water." The plastic cups had "5 ounce" imprinted on the bottom.</p> <p>On 01/09/14 at 3:40 p.m., Staff Member K was asked how she measured the amount of Medpass (protein shake) administered, she stated "I usually eyeball the amount since it is a 4 ounce cup." She stated that the resident was to have 60 cubic centimeters (cc) of the Medpass. She also stated that she usually mixes the Miralax and Metamucil together in one cup and fills it with water, using the 5 ounce cups.</p> <p>Record review of the January 2012 physician orders and medication administration record for Resident #96 revealed the following orders: 1) Miralax 17 grams mixed in 8 ounces of water two times daily; 2) Metamucil 1 scoop mixed in 8 ounces of water three times daily; 3) Med Pass (protein shake) 60 cc three times daily.</p> <p>In summary, the Miralax and the Metamucil were not mixed with the correct amount of water and the Med Pass protein shake was incorrectly measured at approximately 74 cc and not 60 cc as ordered.</p>	F 332		
F 356 SS=E	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> <li>o Facility name.</li> <li>o The current date.</li> <li>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:</li> </ul>	F 356		

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FORM APPROVED  
OMB NO. 0938-0391

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F 356	<p>Continued From page 44</p> <ul style="list-style-type: none"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> <p>o Resident census.</p> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to properly maintain all required components for a daily posting of staff working in the facility. This failure placed residents and visitors at risk of not being accurately informed of the daily staffing levels. Findings include:</p> <p>Observations made from 01/02/14 through 01/10/14 evidenced no staff posting for 01/02/14, 01/03/14, and 01/08/14.</p> <p>On 01/06/14 at 1:10 p.m., Staff Member B, the Resident Care Manager, stated that the Director</p>	F 356	<p><b>F-356</b></p> <p>Daily nurse staffing information posted at East nurses station.</p> <p>Director of Nursing/designee to monitor that information is posted daily.</p> <p>Licensed nurse staff educated on requirement to maintain staffing information posted every shift.</p> <p>Remedies to be completed by 02/28/14.</p>	<p>3/7/14 02/28/14</p>

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F 356	Continued From page 45 of Nursing was responsible for hanging the staff posting. She further explained if there was a "call in" then the licensed nurses on the floor would update the staff posting.  On 01/06/14 at 1:18 p.m. Staff Member A, the Director of Nursing Services stated the night shift nurse was responsible for placing the staff posting up and also stated that she was "ultimately responsible" for making sure the posting was up. She also stated that the licensed floor nurses were responsible to make changes on the posting as needed.  On 01/07/14 at 3:00 p.m., the history of staff postings provided was reviewed; some of the postings were not accurately completed. Staff postings from 11/09/13 through 11/21/13 and 11/27/13 through 11/30/13 were not provided.  On 01/07/14 at 4:55 p.m., Staff Member A stated that she was aware that staff postings had to be completed with census and actual hours worked.	F 356			
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,	F 441			

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F 441	<p>Continued From page 46</p> <p>should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</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</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility: 1) failed to ensure staff disinfected blood glucose machines between residents during 2 of 4 observations potentially affecting Residents #7 and #41; 2) failed to maintain hand washing supplies such as providing paper towels in 1 of 2 dining rooms (North dining) and providing soap for resident and staff use in 1 of 12 resident rooms potentially affecting Residents #106 and #58; and 3) failed to store the ice scoop used for resident hydration in a manner to prevent contamination. These</p>	F 441 <b>F-441</b>	<p>Equipment Cleaning.</p> <p>All blood glucose machines were cleaned per policy.</p> <p>The Licensed staff has been in-serviced on the disinfection of equipment policy dated 07/11.</p> <p>The Director of Nursing/designee will provide oversight to monitor compliance.</p> <p>All hand washing supplies have been restocked including towels and soap dispensers.</p> <p>The housekeeping staff has been in-serviced to check and refill all soap, towel and alcohol based hand cleaner (ABHC) dispensers on a daily basis as they clean each room and hall. All staff, have been in-serviced in the use of the Housekeeping Activity Log. Items requiring restocking are reported by staff on the log, resolved and signed off by the Housekeeping Manager.</p> <p>The Housekeeping Manager or designee will do a monthly inspection of soap, towel and alcohol based hand</p>	

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F 441	<p>Continued From page 47</p> <p>failures put residents at risk for an environment that was not safe or sanitary and increased the chance of the spread of infection. Findings include:</p> <p><b>EQUIPMENT CLEANING</b></p> <p>On 01/08/14 at 11:26 a.m. during a medication pass observation- Staff Member D, a Licensed Nurse (LN), checked Resident #7's blood sugar with a glucose monitor machine (a hand held device where a drop of blood is placed on a disposable strip) and set the machine on top of the medication cart without first cleaning the machine (potentially contaminating the cart surface). The machine stayed on the cart top until the LN used it to check Resident #41's blood sugar at 12:00 p.m. without first cleaning the machine, potentially exposing the resident to blood. After using the machine, she returned the machine to the top of the medication cart without cleaning the machine.</p> <p>On 01/08/14 at 12:30 p.m. Staff Member D, a LN, stated "she did not clean the glucose machine between Residents #7 and #41 because she wore gloves and the machine did not touch the residents." Further she was unaware of a cleaning policy for the glucose monitors but added she would "clean the glucose monitor machine at the beginning of her shift and would clean the top of her medication cart at the end of her shift."</p> <p>On 01/08/14 at 12:40 p.m. Staff Member X, a LN stated she would clean the blood glucose machines with either alcohol wipes or Sani-clothes before and in between uses. She was also unaware of a facility policy to do so but stated "cleaning between uses was just what you</p>	F 441	<p>cleaner dispensers and record the results on the Check of Hand Soap and Paper towels form. A copy of the completed inspection form will be sent to the Administrator.</p> <p>Ice scoops have been placed in sealed plastic containers.</p> <p>Licensed nurses and NAC's and the Dietary Department staff have been in-serviced to store ice scoops on the hydration cart in a sealed container after each use. Guidelines for providing drinking water have been developed for a public hydration pass.</p> <p>The Director of Nursing/designee will provide the oversight to monitor compliance.</p>	<p>3/7/14 02/28/14</p>

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F 441	<p>Continued From page 48 are supposed to do."</p> <p>On 01/09/14 at 11:30 a.m. Staff Member C, a Resident Care Manager, stated "there was one glucose monitor machine for each medication cart. The nurses were required to disinfect the machine with bleach wipes, or Sani-wipes or alcohol swabs in between each resident use, even if machine does not touch the resident."</p> <p>Review of the facility disinfection of equipment policy dated 07/11 revealed it was the policy of the facility to "protect residents from infections with blood borne pathogens from shared glucometers..." The procedure included 1) Glucometers used for multiple resident will be wiped down with approved wipe after each use.. 2) If there is visible organic soilage (sic) on any item after usage, it must be cleaned with a detergent-containing cleaner, allowed to air dry, and then wiped with the bleach solution.</p> <p>On 01/10/14 at 10:35 a.m. Staff Member A, the Director of Nursing, stated "the nurses were to clean the blood glucose monitor machines after each use."</p> <p><b>HAND WASHING &amp; SUPPLIES</b> On 01/02/14 lunch was observed in the North dining room. Staff Member BB, a Nursing Assistant, (NA), and 5 residents were present. Between 12:15 p.m. and 12:40 p.m., Staff Member BB washed her hands several times at the sink and turned off the faucet with her bare hand each time (potentially contaminating her hands). During the dining observation Staff Member BB was observed to handle residents' flatware, served meals and assisted one resident to eat by feeding him. Additionally, the NA passed</p>	F 441		
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F 441	<p>Continued From page 49</p> <p>out two glasses of milk by holding the upper rim (potentially contaminating the drinking surface). Review of the hand washing supplies at the sink revealed there were no paper towels in the dispenser.</p> <p>On 01/06/14 at 1:10 p.m. (4 days later) one resident was finishing his lunch in the North dining room. There were still no paper towels in dispenser at the hand washing sink. Staff Member Y was observed cleaning the counter. When asked why there were no paper towels in the dispenser, she stated "we have been out since last week." Staff Member V, an NA, was in the dining room at this time and confirmed there had not been any paper towels in the dispenser for several days.</p> <p>On 01/06/14 at 1:20 p.m., Staff Member O, a LN, stated she was in the North dining room that day at approximately 12:15 p.m. to pass out the trays and noted the missing paper towels. She stated she had informed Staff Member Q, the Housekeeping Supervisor that there were no paper towels in the North dining room.</p> <p>On 01/06/14 at 3:20 p.m. Resident #106 stated the soap dispenser in her room had been empty for about 7 days. "I need soap to wash my hands after I go to the bathroom and the nursing assistants said they do not have the key for the soap dispenser."</p> <p>On 01/10/14 at 9:50 a.m. Resident #58 stated "I am not able to wash my hands with soap after I go to the bathroom because there was no soap in my room, so the girls would give me a wet wash cloth (without soap) to clean my hands."</p>	F 441		

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F 441	<p>Continued From page 50</p> <p>On 01/10/14 at approximately 9:20 a.m. Staff Member P, an NA, stated she was not aware the soap dispenser was empty in the room Residents #106 and #58 shared. When asked where she washed her hands after providing care for Residents #106 and #58 she responded "I just go to other resident's rooms."</p> <p>On 01/10/14 at 9:45 a.m. Staff Member Y, the housekeeper, stated she was not aware the soap dispenser was empty in the above residents'room. "I wait for the nursing assistants to write down on my housekeeping sheet what needs to be done."</p> <p>Review of the Housekeeping/Maintenance flow sheets hanging at the North nurses station did not include the empty soap dispenser.</p> <p>On 01/10/14 at approximately 10:00 a.m. Staff Member Q, stated "staff should be automatically checking for empty soap dispensers."</p> <p><b>ICE SCOOP</b></p> <p>On 01/06/14 at 9:30 a.m. in the North hall, a cart was set up with ice in an ice chest and an ice scoop placed on towel next to the chest. There was no cover on the ice scoop and residents were observed in the hall next to the cart.</p> <p>On 01/08/14 at 2:45 p.m. in the North hall, an ice chest was positioned on a desk positioned under a wall phone labeled "resident use only." Sitting next to the cooler was an uncovered ice scoop on a paper towel. Residents were noted in the hallway.</p> <p>On 01/09/14 at 11:00 a.m. Staff Member X, a LN, stated the ice was for the residents' hydration.</p>	F 441		

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F 441	Continued From page 51  On 01/09/14 at 12:13 p.m. during observation of the ice chest in the North hallway; Staff Member A, Director of Nursing, stated "the ice scoop should not be lying out in the open and should be protected."  Review of the "Providing Drinking Water" guidelines provided by Staff Member A, revealed the procedure cautioned staff not to let the scoop touch the rim or inside of the pitcher and directed the staff to place the ice scoop on a disposable towel on the cart. Review of the guidance with Staff Member A, on 01/10/14 at 12:30 P.M. stated she was surprised it instructed staff to leave the scoop out; however, she stated the guidance was not intended for ice distribution stationed out in the hallway.	F 441			
F 463 SS=E	<b>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH</b>  The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.  This REQUIREMENT is not met as evidenced by: Based on interview and observation the facility failed to ensure all residents' accessible toilet facilities had means of contacting care givers by way of an emergency call system in 4 of 4 unlocked common use restrooms. Findings include:  Between 01/02/14 and 01/10/14 the facility had four restrooms for common use that remained	F 463	<b><u>F-463</u></b>  The four restrooms have been converted from common use to visitor and employee restrooms by replacing the locks with storage room style. Keys are available at the central nurses station.  Staff have been in-serviced that these restrooms are not for resident use.  The Director of Nursing will provide oversight to assure compliance.	3/2/14 02/28/14	

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F 463	Continued From page 52 unlocked. Each were single use toilet room were accessible to staff, visitors, and residents. There were no emergency call systems in place.  On 01/08/14 at 1:35 p.m. Staff Member R stated the public restrooms were always unlocked and stated she had seen residents use them in the past.  On 01/10/14 at 11:15 a.m. Staff Member D stated the restrooms on the central and north halls remain unlocked and were available to staff and visitors. "We prefer that residents do not use these restrooms; however, I have seen residents use them."	F 463		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON  The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.  This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure 4 of 4 restrooms available for residents, staff, and/or public were in a maintained in a safe and sanitary condition. Findings include:  The following observations were made in the facility's four restrooms on 01/02/14, 01/03/14,	F 465		

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F 465	<p>Continued From page 53 01/06-10/2014 during the on-site survey:</p> <p>East Wing:</p> <p>The 'employee' restroom, left of the employee breakroom, contained a faucet handle on the sink's left side that was round clear plastic. The handle had green matter similar to mold that was viewable inside of the plastic surface.</p> <p>The flooring in front of the toilet and next to the wall was cracked in an approximately six inch line causing an uncleanable surface. Another crack was behind the toilet on the linoleum near the wall also creating an uncleanable surface.</p> <p>There were no available handrails to promote safety.</p> <p>The 'employee' restroom to the right of the employee breakroom had a toilet that did not flush correctly.</p> <p>Neither of the restrooms were locked and both were accessible by residents and public.</p> <p>Center Wing:</p> <p>The restroom to the right of the main dining room did not have hand rails for safety. The left faucet handle leaked continually into the sink.</p> <p>The restroom to the far right of the main dining room did not have hand rails available. The faucet handles had grime under the plastic covering and the left round handle had no covering. The top was open to collect fluid and matter in the well created. There were cracks in the floor near the toilet approximately 4 to 6</p>	F 465	<p><b><u>F-465</u></b></p> <p>The following deficiencies will be corrected, in all four restrooms, in a remodel project that started January 27, 2014 and will conclude by March 31, 2014. New floor coverings, faucets and handrails will be installed in all four (4) restrooms. Fixtures will be removed, repaired and reset.</p> <p>Each of the four restrooms now have locks. Keys are not provided to residents. The east restrooms are labeled for employees. The center restrooms are labeled visitors. Each restroom has a separate key, labeled and stored at the central nurse's station.</p> <p>All staff will be in-serviced in the use of the Maintenance Activity Log and Housekeeping Activity Log. Items requiring action are reported on the logs, resolved and signed off by the Maintenance Director or Housekeeping Manager.</p> <p>Monthly restroom inspections will be conducted by the Administrator and the Housekeeping Manager.</p>	

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505096</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/10/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>TOPPENISH NURSING &amp; REHAB CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>802 WEST THIRD STREET TOPPENISH, WA 98948</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 465	Continued From page 54 inches long and one area behind the door was without linoleum. Those areas were uncleanable surfaces.  Neither of the restrooms were locked and both were accessible by residents and public.	F 465		
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