

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

1356

PRINTED: 09/17/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505016	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  09/09/2013
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NAME OF PROVIDER OR SUPPLIER  GRAYS HARBOR HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 920 ANDERSON DRIVE ABERDEEN, WA 98520
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Grays Harbor Health and Rehabilitation Center on 09/03/13, 09/04/13, 09/05/13, 09/06/13, and 09/09/13. A sample of 37 residents was selected from a census of 85. The sample included 31 current residents and the records of 6 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>██████████ BSS ██████████ RN, BSN ██████████ RN, BSN</p> <p>The survey team is from:</p> <p>Department of Social &amp; Health Services Aging &amp; Disability Services Administration Residential Care Services, District 3, Unit C P.O. Box 45819 Olympia, Washington 98504-5819</p> <p>Telephone: 360.664.8429 Fax: 360.664.8451</p> <p>██████████ Residential Care Services</p>	F 000	<p>RECEIVED OCT 10 2013 DSHS/ADSA/RCS</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  ██████████	TITLE Administrator	(X6) DATE 10-2-13
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1	F 000	F - 154	
F 154 SS=D	<p>483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, &amp; TREATMENTS</p> <p>The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.</p> <p>The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to obtain informed consent for psychotropic medications for 2 of 5 residents (#91, 132) reviewed for unnecessary medications. This deficiency placed residents at risk of experiencing side effects without being informed of the risks and benefits of the medications.</p> <p>&lt;Record Review&gt; Resident #91's medical record lacked documentation of informed consent for use of a psychotropic medication. The facility failed to explain risks and benefits of [REDACTED], an anti-depressant prior to administering the medication.</p> <p>Review of the resident's medication administration record (MAR) confirmed the resident had received the medication prior to appropriate consent.</p>	F 154	<p><b>How the nursing home will correct the deficiency as it relates to this resident</b></p> <p>The consents for psychotropic medication were obtained from the responsible parties on the resident # 91 and resident # 132</p> <p><b>How the nursing home will act to protect residents in similar situations</b></p> <p>An audit will be done of current residents receiving psychotropic medications to assure informed consents have been completed for each affected resident. A new consent will be obtained on admission, change in medication or dose, and yearly on affected residents.</p> <p><b>Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur</b></p> <p>Training has been provided to nursing staff regarding policy and procedure to administer psychotropic medications and time frame consents are to be obtained within.</p> <p>Unit Managers will audit resident's with psychoactive medications on admit, change in dose or medication</p>	

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F 154	<p>Continued From page 2</p> <p>Resident #132's medical record lacked documentation of informed consent for the use of ██████████, an anti-depressant medication. The facility failed to explain the risks and benefits of the medication prior to administering it to the resident.</p> <p>Review of the resident's (MAR) confirmed the resident had received the medication prior to appropriate consent.</p> <p>&lt;Staff Interviews&gt; On 09/05/13 at 11:05 a.m., Licensed Nurse (LN) A confirmed informed consent forms were not in the medical charts for Residents #91 and 132 and stated the facility normally get informed consents on admittance to the facility.</p> <p>On 09/05/13 at 3:41 p.m., the Director of Nursing Services stated, "It is expected that informed consent is given by the resident or the resident's representative prior to medication being administered.</p> <p>At 4:25 p.m., LN A stated after further review she was still unable to locate documentation of informed consent. The LN stated she would talk with the families and have them sign consents as soon as possible.</p>	F 154	<p>and quarterly to ensure an informed consent is present in resident record.</p> <p><b>How the nursing home plans to monitor its performance to make sure that the solutions are sustained</b></p> <p>Psychotropic consents will be reviewed quarterly during Psychotropic Drug Committee Meeting</p> <p><b>Date when the corrective action will be completed</b></p> <p>11 October 2013</p> <p><b>The title of the person responsible to ensure completion:</b></p> <p>Nursing Home Administrator.</p>
F 155 SS=D	<p>483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES</p> <p>The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as</p>	F 155	

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F 155	<p>Continued From page 3 specified in paragraph (8) of this section.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to educate the resident of the risks of refusal, or ascertain or address the resident's reason for refusal, for 1 of 1 sampled resident (Resident #161) who the facility stated refused provisions of care and services to prevent pressure ulcers from developing or worsening. This failure placed the resident at risk of insufficient information related to treatment of his condition, putting him at risk for worsening or delayed healing of an existing pressure ulcer and the potential for development of new pressure ulcers.</p> <p>Findings include:</p> <p>Resident #161 was admitted to the facility from the hospital on [REDACTED]/13 with diagnoses to include</p>	F 155	<p><b>F - 155</b></p> <p><b>How the nursing home will correct the deficiency as it relates to this resident.</b></p> <p>The reason for resident's refusal has been identified. Risks and benefits were reviewed with resident .</p> <p><b>How the nursing home will act to protect residents in similar situations</b></p> <p>The cause of a resident's refusal to follow treatment plan will be identified and possible adjustments to plan will be assessed. The risks / benefits will be reviewed with resident and/or family when the treatment plan is not followed by resident.</p> <p><b>Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur.</b></p> <p>Training was provided to the nursing staff on assessing reason of non-compliance and completing risks and benefits.</p> <p>Unit Managers will audit interventions during weekly rounds. Refusal of treatments will be assessed for possible change to treatment plan and/or Risk and Benefits related non-compliance of plan.</p>	
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F 155	<p>Continued From page 4</p> <p>██████ and a history of ██████ of one ██████. The resident was alert, oriented and able to make his needs known. Nursing notes consistently indicated the resident was pleasant, cooperative with care and treatment, and required maximum 2 person assistance with bed mobility and use of a Hoyer mechanical lifting device for all transfers.</p> <p>The facility policy regarding pressure ulcers instructed licensed staff to engage the resident in the plan of care related to positioning, and document success at gaining the resident's participation and the resident's understanding of teaching related to repositioning to relieve pressure.</p> <p>The nursing admission note written on ██████/13 at 10:48 p.m. reported that Resident #161 was admitted at 3:20 p.m. and that the resident had a "reddened ██████."</p> <p>Resident #161's care plan, dated 8/5/13, instructed staff to encourage and assist the resident to turn and reposition every 1 to 2 hours due to potential for impaired skin integrity.</p> <p>The care plan instructed staff to educate and encourage Resident #161 to shift his weight every 15 minutes while sitting in his wheelchair but did not specifically address educating the resident about repositioning while in bed.</p> <p>The Weekly Pressure Sore Record (WPSR) documented that on 8/11/13 Resident #161 had a Stage 1 pressure ulcer on his coccyx measuring 1 x 2 centimeters (cm).</p> <p>On 8/21/13, the WPSR indicated Resident #161</p>	F 155	<p><b>How the nursing home plans to monitor its performance to make sure that the solutions are sustained.</b></p> <p>Review of residents that are not complying with their care plans weekly in the Interdisciplinary Meeting.</p> <p><b>Date when the corrective action will be completed</b></p> <p>11 October 2013</p> <p><b>The title of the person responsible to ensure completion:</b></p> <p>Nursing Home Administrator.</p>	
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F 155	<p>Continued From page 5</p> <p>had a Stage 2 ulcer on his coccyx measuring 3 x 4 cm.</p> <p>On 8/30/13, the facsimile sent to the physician stated the resident had an "open area, non-stageable pressure ulcer to coccyx area, approximately 1.7 x 1 cm x 0.1 cm depth with white slough/ 20% pink."</p> <p>Multiple observations on different dates and times throughout the 5 day survey noted Resident #161 lying in bed. He was also observed sitting in his wheelchair. Each time the surveyor observed the resident in bed, he was lying on his back with no evidence of pillows or foam wedges placed to position the resident off of his coccyx.</p> <p>On 9/4/13 at 13:11 p.m., Resident #161 was observed grimacing as he shifted his weight in his wheelchair. The resident told the surveyor he had a painful wound on his tailbone but he did not like to take medication.</p> <p>On 9/6/13, at 10:15 a.m., review of Resident #161's Treatment Administration Record revealed no documentation of turning and repositioning.</p> <p>At 10:25 a.m., at the nursing station, the surveyor informed LN B she wanted to discuss Resident #161's pressure ulcer and would like to see documentation that the resident was being repositioned according to his care plan. LN B showed the surveyor random occasional nursing notes indicating the resident was on a turn schedule. LN B got up to leave and said she would be right back.</p> <p>When LN B returned at 10:30 a.m., she told the surveyor that LN C just informed her that</p>	F 155		

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F 155	<p>Continued From page 6</p> <p>whenever staff members repositioned Resident #161 off of his coccyx, he repositioned himself back onto his coccyx.</p> <p>At 10:33 a.m., LN C presented the surveyor with a document she said she just had Resident #161 sign, entitled "Benefits vs. Risks (Refusal to Treat)," dated 9/6/13, signed by Resident #161, which read: "When placed on his side, he rolls onto his back."</p> <p>Under "Benefits," an arrow pointing up and the words "skin integrity" were written. Under "Risks Related to Noncompliance," an arrow pointing down and the words "skin integrity" were written along with an arrow pointing up and the words "chance for infection."</p> <p>Above Resident #161's signature was the statement, "The above information has been reviewed with me. I understand the potential risks of my noncompliance with current physician's orders."</p> <p>At 11:32 a.m., during an interview, the DNS reported that earlier in the day she observed Resident #161 lying on his back and asked LN C about it. The DNS stated LN C informed her that staff were positioning the resident off of his coccyx but he would not stay in that position. The DNS stated she had been unaware this was occurring and said, "It is my expectation that staff will document when they reposition a resident who is on a turn schedule and, if the resident declines to be repositioned off the affected area or repositions himself back onto the area, there will be documentation of that."</p> <p>The DNS was unable to locate documentation</p>	F 155		

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F 155	<p>Continued From page 7</p> <p>that Resident #161 was not compliant with repositioning, nor was she able to produce a care plan addressing the resident's noncompliance. The DNS was unable to locate documentation to verify any attempts by staff to ascertain or address the resident's reason for noncompliance or any attempts by staff to educate Resident #161 about the rationale for repositioning prior to the Benefits vs. Risk document signed by the resident at approximately 10:30 a.m. that morning (9/6/13), a full month after the pressure ulcer was identified and the care plan for repositioning was written (8/5/13).</p> <p>At 1:47 p.m., observation of the pressure ulcer on Resident #161's coccyx noted the appearance of the wound to be consistent with LN B's documentation on the WPSR, dated 9/6/13: Stage 2 with the wound bed measuring 1.5 x 1 cm x 0.1 cm deep. Surrounding skin white, measuring 2 x 1.5 cm.</p> <p>The facility's failure to educate Resident #161 of the risks of refusal with repositioning, or ascertain or address the resident's reason for refusal, placed the resident at risk of insufficient information related to treatment and increased the potential for delayed healing of an existing pressure ulcer.</p> <p>Refer to F 314.</p>	F 155			
F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if</p>	F 157			

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F 157	<p>Continued From page 8</p> <p>known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to notify the physician when a Stage 2 pressure ulcer developed for 1 of 3 residents reviewed for pressure ulcers (Resident #161). This failure caused a delay in treatment and placed the resident at risk for complications including</p>	F 157	<p><b>F - 157</b></p> <p><b>How the nursing home will correct the deficiency as it relates to this resident.</b></p> <p>The Physician has been informed of resident's pressure ulcer. Area has now healed.</p> <p><b>How the nursing home will act to protect residents in similar situations.</b></p> <p>Training has been provided to nursing staff to inform the physician of changes in resident condition, including residents admitted with skin issues, new skin issues, or changes with skin issues.</p> <p><b>Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur.</b></p> <p>Training has been provided to nursing staff to inform the physician of changes in resident condition, including residents admitted with skin issues, new skin issues, or changes with skin issues.</p> <p>Unit managers will audit notifications of changes in condition to physicians, residents, and/or family weekly.</p>	

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F 157	<p>Continued From page 9</p> <p>infection, delayed healing, and prolonged pain and discomfort.</p> <p>Findings include:</p> <p>Resident #161 was admitted to the facility from the hospital on [REDACTED]/13 with diagnoses to include [REDACTED] and a history of [REDACTED] of one [REDACTED]. Nursing notes consistently indicated the resident required maximum 2 person assistance with bed mobility and use of a Hoyer mechanical lifting device for transfers.</p> <p>The facility policy regarding pressure ulcers instructed licensed staff to notify the physician when a pressure ulcer was identified, obtain orders for each pressure ulcer and transcribe orders onto the Treatment Administration Record (TAR).</p> <p>The nursing admission note written on [REDACTED]/13 at 10:48 p.m. reported that Resident #161 was admitted at 3:20 p.m. and that the resident had a "[REDACTED]."</p> <p>The Weekly Pressure Sore Record (WPSR) documented that on 08/11/13 Resident #161 had a Stage 1 pressure ulcer on his coccyx, without apparent pain, measuring 1 x 2 centimeters (cm).</p> <p>On 08/21/13, the WPSR indicated Resident #161 had a Stage 2 ulcer on his coccyx measuring 3 x 4 cm.</p> <p>On 08/30/13, the ulcer was non-stageable, measuring 1.7 x 1 cm, and was causing the resident episodic pain.</p> <p>The physician's Nursing Home Note, dated</p>	F 157	<p><b>How the nursing home plans to monitor its performance to make sure that the solutions are sustained.</b></p> <p>Changes of condition will be reviewed weekly in Interdisciplinary Team Meeting.</p> <p><b>Date when the corrective action will be completed</b></p> <p>11 October 2013</p> <p><b>The title of the person responsible to ensure completion:</b></p> <p>Nursing Home Administrator.</p>

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F 157	<p>Continued From page 10</p> <p>08/20/13, indicated she was not aware of the pressure ulcer.</p> <p>Resident #161's physician was not notified of the pressure ulcer until 08/30/13 (25 days after it was identified) and after the ulcer had progressed to "open, non-stageable."</p> <p>The facsimile sent to the physician, dated 08/30/13, stated the resident had an "open area, non-stageable pressure ulcer to coccyx area, approximately 1.7 x 1 cm x 0.1 cm depth with white slough/ 20% pink."</p> <p>Physician's orders, dated 8/30/13, included:</p> <p>1) "Cleanse open area to coccyx with wound cleaner, pat dry, apply [REDACTED] to slough, cover with [REDACTED] and a foam dressing. Change twice daily and as needed."</p> <p>These wound treatments were transcribed onto the TAR on 8/30/13 and implemented that evening.</p> <p>2) "Air mattress to promote wound healing."</p> <p>"Air mattress to promote wound healing," was transcribed onto the TAR on 8/30/13 (25 days after the wound was identified).</p> <p>Refer to F 314.</p>	F 157		
F 160 SS=D	<p>483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH</p> <p>Upon the death of a resident with a personal fund</p>	F 160		

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F 160	<p>Continued From page 11</p> <p>deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to convey resident trust account funds within 30 days after the resident's expiration for 2 of 5 residents (#13, &amp; 14) reviewed for conveyance of personal funds upon death. This deficient practice placed residents at risk of lost or misappropriated funds.</p> <p>On 09/09/13 at 11:50 a.m., a review of residents with trust accounts who had expired within the previous five months was completed with the Business Office Manager (BOM).</p> <p>Accounting records indicated that resident 13# expired on [REDACTED]/13 and the resident's funds were processed for transmittal on [REDACTED]/13, 39 days after the resident's death.</p> <p>When asked to explain the amount of time Resident #13's funds were held at the facility, the BOM stated, "We screwed up. We have a problem."</p> <p>Accounting records indicated Resident #14 expired on [REDACTED] 13 and the resident's funds were processed for transmittal on [REDACTED]/13, 31 days after the resident's death.</p> <p>When asked about meeting the 30 day regulatory</p>	F 160	<p><b>F 160</b></p> <p><b>How the nursing home will correct the deficiency as it relates to this resident</b></p> <p>All funds were refunded as required.</p> <p><b>How the nursing home will act to protect residents in similar situations</b></p> <p>Resident funds will be returned within seven days of discharge or within 30 days of death.</p> <p><b>Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur</b></p> <p>The daily census will be monitored by the Administrative Services Director and funds transfer initiated upon changes in resident status</p> <p><b>How the nursing home plans to monitor its performance to make sure that the solutions are sustained</b></p> <p>The Administrative Services Director will audit discharges and trust accounts weekly.</p> <p><b>Date when the corrective action will be completed</b></p> <p>11 October, 3013</p> <p><b>The title of the person responsible to ensure completion:</b></p> <p>Nursing Home Administrator.</p>	
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F 160	Continued From page 12  requirement for the release of resident funds, the BOM confirmed the transmittal of Resident 14's funds failed to meet that requirement.  The facility policy titled, Patient Trust Policy and Procedure, stated, "The facility will refund patient trust accounts of patients which have been discharged from the facility within 30 days or according to state guidelines. Upon death of a resident, the facility shall promptly convey the resident's personal funds held by the facility with a final accounting of such funds to the individual documented or to the person (s) administering the resident's estate.	F 160		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to conduct ongoing assessments to evaluate resident clinical condition, define and implement interventions consistently, recognize standards of practice, monitor and evaluate the impact of	F 314		

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F 314	<p>Continued From page 13</p> <p>interventions and/or revise interventions appropriately to provide timely necessary treatment and services to ensure that a resident without a pressure ulcer did not develop one, and to promote healing when a pressure ulcer did develop in 1 of 3 residents (Resident #161) reviewed for pressure ulcers. This failure resulted in the development of a painful, ongoing Stage 2 pressure ulcer causing harm to the resident.</p> <p>Findings include:</p> <p>Resident #161 was admitted to the facility from the hospital on [REDACTED]/13 with diagnoses to include [REDACTED] and a history of [REDACTED] of [REDACTED]. The resident was generally alert, oriented and able to make his needs known but nursing notes documented he had periods of confusion. Nursing notes consistently indicated the resident was pleasant, cooperative with care and treatment, and required maximum 2 person assistance with bed mobility and use of a Hoyer mechanical lifting device for all transfers.</p> <p>On 09/06/13, when asked for a copy of the facility policy on pressure ulcers, the Director of Nursing Services (DNS) provided a document entitled Pressure Sore (ulcer) Monitoring Guidelines. The written policy stated the facility goal was to maintain skin integrity, promote healing and prevent new ulcers from developing. The policy instructed staff regarding measures to take when a pressure ulcer was identified, including: 1) gather accurate, consistent data, 2) notify the physician of pressure ulcers and transcribe treatments onto the Treatment Administration Record (TAR), 3) ensure that pressure ulcer identification, goals and interventions are addressed on the resident's care plan, 4)</p>	F 314	<p><b>F - 314</b></p> <p><b>How the nursing home will correct the deficiency as it relates to this resident.</b></p> <p>The pressure ulcer for resident # 161 has resolved.</p> <p><b>How the nursing home will act to protect residents in similar situations.</b></p> <p>Current residents with pressure ulcers will be assessed, their physicians updated with the current assessment, treatment of pressure ulcer will be instituted, and plan of care updated.</p> <p><b>Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur.</b></p> <p>Training has been provided to Unit Managers and licensed staff on Policy and Procedure of Pressure Ulcers.</p> <p>Unit Managers will audit implementation of Pressure Ulcer Policy during weekly wound rounds.</p> <p><b>How the nursing home plans to monitor its performance to make sure that the solutions are sustained.</b></p> <p>Pressure Ulcers to be reviewed weekly in Interdisciplinary Team Meeting.</p>

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F 314	<p>Continued From page 14</p> <p>implement the recommended Braden Assessment Decision Tree (BADT) measures for maintaining and/or improving skin integrity within 24 hours and complete interventions within 72 hours, and 5) document resident understanding and participation with interventions such as repositioning for pressure relief.</p> <p>According to the facility Pressure Sore Staging Protocol, a Stage 1 pressure ulcer was a "Non-blanchable erythema (redness) of intact skin; the heralding lesion of skin ulceration." A Stage 2 ulcer was a "Partial thickness loss of dermis presenting as a shallow open ulcer with a pink wound bed, without slough." An Unstageable [or non-stageable] ulcer had "Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black)."</p> <p>Document review revealed the facility failed to follow its pressure ulcer policy for maintaining and/or improving skin integrity for Resident #161 as follows:</p> <p>Documentation related to the pressure ulcer on Resident #161's coccyx was not accurate and consistent.</p> <p>The nursing admission note written on [redacted]/13 at 10:48 p.m. reported that Resident #161 was admitted at 3:20 p.m. and that the resident had a "reddened coccyx."</p> <p>The Weekly Pressure Sore Record (WPSR) documented that on [redacted]/13 Resident #161 had a Stage 1 pressure ulcer on his coccyx measuring 1 x 2 centimeters (cm) without apparent pain and indicated that the pressure</p>	F 314	<p><b>Date when the corrective action will be completed</b></p> <p>11 October 2013</p> <p><b>The title of the person responsible to ensure completion:</b></p> <p>Nursing Home Administrator.</p>	
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F 314	<p>Continued From page 15</p> <p>ulcer developed when the resident was in the hospital.</p> <p>On 08/21/13, the WPSR indicated Resident #161 had a Stage 2 ulcer on his coccyx measuring 3 x 4 cm.</p> <p>On 08/30/13, the ulcer was non-stageable, measuring 1.7 x 1 cm, and was causing the resident episodic pain.</p> <p>Despite identification of the pressure ulcer in the admission note and on the WPSR, the admission Minimum Data Set (MDS), an assessment tool, dated 08/12/13, one day after a Stage 2 pressure ulcer was identified and documented, reported that Resident #161 was at risk of developing pressure ulcers but stated he did not currently have any pressure ulcers at Stage 1 or higher.</p> <p>The MDS assessment reflected Resident #161's Braden Scale assessments, a tool for predicting pressure ulcer risk. On 08/05/13 and 08/11/13, Resident #161's Braden score was 12, indicating he had a moderate risk of developing a pressure ulcer. There was no indication in the Braden Scale assessments that a pressure ulcer had already developed.</p> <p>In an e-mail to the surveyor on 9/11/13, the Administrator stated the facility did not receive any documented skin assessments from the hospital when Resident #161 was admitted on [REDACTED]/13, thus the status of the resident's skin integrity when he left the hospital was unknown.</p> <p>Resident #161's physician was not timely notified of the pressure ulcer, causing a delay in treatment. The reddened coccyx was first</p>	F 314		

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F 314	<p>Continued From page 16</p> <p>documented on 8/5/13. The physician was notified of the pressure ulcer 25 days later, on 8/30/13, after the ulcer had progressed to "open, non-stageable."</p> <p>The physician's Nursing Home Note, dated 8/20/13, indicated she was not aware of the pressure ulcer.</p> <p>The facsimile sent to the physician, dated 8/30/13, stated the resident had an "open area, non-stageable pressure ulcer to coccyx area, approximately 1.7 x 1 cm x 0.1 cm depth with white slough/ 20% pink."</p> <p>Physician's orders, dated 08/30/13, included "Cleanse open area to coccyx with wound cleaner, pat dry, apply [REDACTED] to slough, cover with [REDACTED] and a foam dressing. Change twice daily and as needed." These treatments were transcribed onto the TAR on 8/30/13 and implemented that evening.</p> <p>Resident #161's care plan, dated 08/05/13, identified a potential for impaired skin integrity but was not revised to identify the pressure ulcer on the resident's coccyx, nor was the care plan revised to include the interventions ordered on 8/30/13.</p> <p>Some BADT interventions for maintaining and/or improving skin integrity were incorporated into Resident #161's care plan within 24 hours of the admission skin assessment on 08/05/13, but not all interventions were completed within 72 hours (as directed by facility policy).</p> <p>The facility failed to implement Resident #161's care plan as follows:</p>	F 314		

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Continued From page 17

A) The care plan, dated 08/05/13, called for "pressure reducing devices to bed and wheelchair."

Document review indicated a pressure reducing device was not placed on Resident #161's wheelchair until 8/18/13, and a pressure reducing device was not placed on his bed until 08/21/13, 10 days after the pressure ulcer was identified.

The nursing note dated 08/18/13 at 11:55 a.m., stated "I placed a ROHO [pressure reducing] mattress in [Resident #161's] wheelchair and faxed the MD about getting an air mattress. Waiting for a reply."

The earliest documentation indicating a pressure reducing device was placed on Resident #161's bed was a nursing note dated 08/21/13 at 11:51, stating "[Resident #161] has a ROHO cushion in his chair and an air mattress in place." (The physician wrote an order for an air mattress on 8/30/13.)

B) The care plan, dated 8/5/13, instructed staff to "encourage and assist resident to turn and reposition every 1 to 2 hours."

Multiple observations on different dates and times throughout the 5 day survey noted Resident #161 lying in bed. He was also observed sitting in his wheelchair. Each time the surveyor observed the resident in bed, he was lying on his back with no evidence of pillows or foam wedges placed to position the resident off of his coccyx. The resident's bed had a ROHO Sofflex 2 (a non-powered manually adjustable overlay air mattress) placed on top of a standard mattress.

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F 314	<p>Continued From page 18</p> <p>There was a ROHO pad on the seat of his wheelchair. The resident was noted on multiple occasions to grimace as he lay on his back in bed or while sitting in his wheelchair.</p> <p>On 09/04/13 at 13:11 p.m., Resident #161 was observed grimacing as he shifted his weight in his wheelchair. The resident told the surveyor his tailbone hurt but he did not like to take medication.</p> <p>On 9/6/13, at 10:15 a.m., review of Resident #161's TAR revealed no documentation of turning and repositioning.</p> <p>At 10:25 a.m., at the nursing station, the surveyor informed LN B she wanted to discuss Resident #161's pressure ulcer and would like to see documentation that the resident was being repositioned according to his care plan. LN B showed the surveyor random occasional nursing notes indicating the resident was on a turn schedule. LN B got up to leave and said she would be right back.</p> <p>When LN B returned at 10:30 a.m., she told the surveyor that LN C just informed her that whenever staff members repositioned Resident #161 off of his coccyx, he repositioned himself back onto his coccyx.</p> <p>At 11:32 a.m., during an interview, the DNS reported that earlier in the day she observed Resident #161 lying on his back and asked LN C about it. The DNS stated LN C informed her that staff were positioning the resident off of his coccyx but he would not stay in that position. The DNS stated she had been unaware this was occurring and said, "It is my expectation that staff</p>	F 314		

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F 314	<p>Continued From page 19</p> <p>will document when they reposition a resident who is on a turn schedule and, if the resident declines to be repositioned off the affected area or repositions himself back onto the area, there will be documentation of that."</p> <p>The DNS was unable to locate documentation that Resident #161 was not compliant with repositioning, nor could she locate a care plan addressing the resident's noncompliance. The DNS was unable to locate documentation to verify any attempts by staff to ascertain or address the resident's reason for noncompliance or any attempts by staff to educate Resident #161 about the rationale for repositioning.</p> <p>At 1:47 p.m., observation of the pressure ulcer on Resident #161's coccyx noted the appearance of the wound to be consistent with LN B's documentation on the WPSR, dated 09/06/13: Stage 2 with the wound bed measuring 1.5 x 1 cm x 0.1 cm deep. Surrounding skin white, measuring 2 x 1.5 cm. No foul odor or evidence of infection noted.</p> <p>The facility's failure to accurately and consistently assess and document the pressure ulcer, timely notify the physician, timely initiate interventions or review and revise the care plan as needed, resulted in the development of a painful, ongoing Stage 2 pressure ulcer on Resident #161's coccyx.</p>	F 314		
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident</p>	F 323		

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F 323	<p>Continued From page 20</p> <p>environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure that the resident environment was free of accident hazards for 1 of 4 current residents (Resident #161) reviewed for accidents. This failure to assess for bed rail use and potential entrapment hazard placed the resident at risk of becoming entrapped in the bed rails or between the bed rails and the mattress.</p> <p>Findings include:</p> <p>Resident #161 was admitted to the facility from the hospital on [REDACTED]/13 with diagnoses to include [REDACTED] and a history of [REDACTED] of [REDACTED]. The resident was generally alert, oriented and able to make his needs known but nursing notes indicated he had periods of confusion. Nursing notes further indicated the resident required assistance of 2 persons with bed mobility and use of a Hoyer mechanical lifting device for transfers. He was [REDACTED] feet, [REDACTED] inches tall and weighed [REDACTED] pounds.</p> <p>The facility policy for use of bed rails stated that before rails could be placed on a resident bed, an evaluation must be conducted to determine the resident's need for side rails and potential risk for entrapment, and a physician order must be</p>	F 323	<p><b>F - 323</b></p> <p><b>How the nursing home will correct the deficiency as it relates to this resident.</b></p> <p>Resident #161 was assessed for side rail use and risk of entrapment.</p> <p><b>How the nursing home will act to protect residents in similar situations.</b></p> <p>Resident's with side rails will be assessed for entrapment and safety risks, and the plan of care updated as needed.</p> <p><b>Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur.</b></p> <p>Unit Managers will audit resident's with side rails weekly to check for assessment, order, and documentation.</p> <p><b>How the nursing home plans to monitor its performance to make sure that the solutions are sustained.</b></p> <p>Resident's with side rails will be reviewed on initiation of side rails and quarterly during Interdisciplinary Team Meeting.</p> <p><b>Date when the corrective action will be completed</b></p> <p>11 October 2013</p>	
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505016</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/09/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRAYS HARBOR HEALTH &amp; REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>920 ANDERSON DRIVE ABERDEEN, WA 98520</b>		
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F 323	<p>Continued From page 21</p> <p>obtained. The gap between the inside surface of the bed rail and the mattress must be less than 4 3/4 inches.</p> <p>On 09/04 and 09/05/13, Resident #161's bed was observed to have 2 bed rails. On the left side was a rail approximately 3 feet in length with a 3 to 4 inch gap between the rail and the mattress. On the right was a rail approximately 11 inches in length which was snug against the mattress.</p> <p>The form entitled Evaluation of Need for Side Rails and Potential for Entrapment Hazards, dated 08/05/13 stated, signed by LN B, indicated that, for Resident #161, side rails were "not needed at this time."</p> <p>Review of Resident #161's record revealed no evaluation for side rails and no physician's order for side rails. The resident's care plan did not address side rails.</p> <p>On 09/06/13 at 10:32 a.m., during an interview, LN B was unable to locate documentation to verify that Resident #161 was evaluated for use of bed rails and potential for entrapment or that a physician's order was obtained.</p> <p>At 11:28 a.m., during an interview, the DNS was unable to locate documentation to verify that Resident #161 was assessed for appropriateness of bed rails or potential entrapment hazard, and said the rails should not have been placed on his bed. The DNS stated that Resident #161 used the rails for bed mobility and repositioning but she was not sure he would be able to use the call light if he became entrapped. "He is really alert at times but he has episodes of confusion."</p>	F 323		

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F 323 Continued From page 22  
At 1:10 p.m., during an interview, the DNS stated the facility policy for bed rails was that residents must be assessed by physical therapy or nursing for appropriateness for bed rails and for potential entrapment hazard. She stated, "We dropped the ball. We didn't have good communication. We didn't do an assessment before putting rails on his bed."  
  
Refer to F 314.

F 323

F 371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  
SS=F  
  
The facility must -  
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and  
(2) Store, prepare, distribute and serve food under sanitary conditions  
  
This REQUIREMENT is not met as evidenced by:  
Based on observation and interview, it was determined the facility failed to ensure food was prepared and served under sanitary conditions. This failure placed all residents at risk of consuming potentially contaminated food.  
  
Findings include:  
  
On 09/03/13 at 11:50 a.m., the kitchen was observed with the Dietary Manager (DM). The

F 371

**F - 371**  
  
**How the nursing home will correct the deficiency as it relates to this resident**  
  
The dietary department will conduct a deep cleaning of the kitchen. Dietary staff will be involved with a ceiling to wall to floor deep scrubbing. These deep cleanings will take place quarterly. Monthly deep cleaning & buffing of the tile floors will be done by the House Keeping Department.  
The weekly cleaning schedule has been updated to include items noted as deficient during survey.

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F 371	<p>Continued From page 23</p> <p>counter top fan was observed to have a layer of dust and greasy residue covering all the fan surfaces, including the safety cage and blades. The fan was on and was blowing air across lettuce, tomatoes and onions being prepped for lunch. A radio and stand mixer located next to the fan were observed to be covered in dust and greasy residue.</p> <p>Large plastic spice containers, located on a shelf above the fan, were covered in crusty dust and grime. The spice containers were open, undated, and had spices stuck to the inside of the lids.</p> <p>The hood vent over the stove was covered in a layer of greasy dust. All of the exposed pipes in the kitchen were covered in a layer of dust and grease. The electrical face plates were covered with greasy dust and the wall surrounding them had dried food splatter. An electrical cord plugged into the wall socket had a layer of greasy dust covering its top half.</p> <p>The toaster had a layer of dust on its top and the catch tray was full of crumbs.</p> <p>The floors of the kitchen and dishwashing area were observed to have cracked tiles with black residue in the cracks. The traffic areas of both floors were sticky when walked upon.</p> <p>On 09/06/13 at 12:29 p.m. and 09/09/13 at 11:50 a.m., the kitchen was observed during lunch service. The DM was present during both observations.</p> <p>The fan was covered with greasy dust and was blowing air across produce being prepared for salads. The stand mixer and radio next to the fan</p>	F 371	<p><b>How the nursing home will act to protect residents in similar situations</b></p> <p>The dietary department will conduct a deep cleaning of the kitchen. Dietary staff will be involved with a ceiling to wall to floor deep scrubbing. These deep cleanings will take place quarterly. Monthly deep cleaning &amp; buffing of the tile floors will be done by the House Keeping Department.</p> <p>The weekly cleaning schedule has been updated to include items noted as deficient during survey. Plans will be submitted requesting funds to replace the kitchen floors within one year's time</p> <p><b>Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur</b></p> <p>A monthly inspection will be conducted with participation by at least two of the following: Administrator; DNS; Dietician; or House Keeping Supervisor.</p>	
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F 371 Continued From page 24  
were covered in grease and dust.

The large spice containers on the shelf above the fan had streaks of dust which appeared to have been wiped with a wet cloth.

The vent hood and all the exposed pipes in the kitchen were covered with layers of dust and grease, as were the electrical faceplates. Dried food splatter was on the walls around the faceplates.

The floors of the kitchen and dishwashing area had cracked tiles filled with black residue.

On 09/09/13 at 2:45 p.m., the DM agreed the areas of concern were covered with grease, dust, or a combination of both. The DM stated the maintenance department was responsible for deep cleaning the kitchen every other month during the night shift. The DM confirmed the dust and grease were older than two months.

F 371

**How the nursing home plans to monitor its performance to make sure that the solutions are sustained**

A monthly inspection will be conducted with participation by at least two of the following:  
Administrator; DNS; Dietician; or House Keeping Supervisor.

**Date when the corrective action will be completed**

11 October 2013

**The title of the person responsible to ensure completion:**

Nursing Home Administrator.

F 431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  
SS=D

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted

F 431

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F 431	<p>Continued From page 25</p> <p>professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure that 1 of 3 medication storage refrigerators was operating within the proper temperature range, placing residents at risk of receiving potentially ineffective medications.</p> <p>Findings include:</p> <p>On 09/06/13, at 12:30 p.m., observation revealed there was no written log in the first floor medication room documenting temperatures of the medication refrigerator in that room. The thermometer in the refrigerator registered 38</p>	F 431	<p><b>F - 431</b></p> <p><b>How the nursing home will correct the deficiency as it relates to this resident.</b></p> <p>Temperature logs are in place for medication refrigerators with current temperatures documented for each.</p> <p><b>How the nursing home will act to protect residents in similar situations.</b></p> <p>A temperature log will be maintained on refrigerators in use for medication.</p> <p><b>Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur.</b></p> <p>Unit Managers to audit temperature logs weekly.</p> <p><b>How the nursing home plans to monitor its performance to make sure that the solutions are sustained.</b></p> <p>DON or designee to review refrigerator logs monthly.</p> <p><b>Date when the corrective action will be completed</b></p> <p>11 October 2013</p> <p><b>The title of the person responsible to ensure completion:</b></p> <p>Nursing Home Administrator.</p>

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F 431	<p>Continued From page 26</p> <p>degrees Fahrenheit. Contents of the refrigerator included:</p> <p>One vial of [REDACTED] One box of [REDACTED] suppositories One box of [REDACTED] suppositories Eleven vials of insulin (3 [REDACTED], 4 [REDACTED], 4 [REDACTED])</p> <p>The vials of insulin and [REDACTED] were examined and found to be in liquid form, not frozen or crystalized.</p> <p>At 12:40 p.m., when asked to provide temperature logs for the first floor medication room refrigerator, LN B was unable to locate them.</p> <p>At 3:00 p.m., the DNS presented the surveyor with the daily logs for the first floor medication room entitled Medication Refrigerator Temperature Log, dated August and September 2013. The document did not provide a place to write the exact temperature. Rather it only provided a place to indicate "Y" or "N" (yes or no) in a column labeled "Temperatures &lt; [less than] 41 degrees." For each day between 08/01/13 and 9/6/13, "Y" was circled.</p> <p>There was no place on the document to indicate whether the temperature was above freezing, no place to document what, if any, action was taken if the temperature was not less than 41 degrees, and the document did not provide information regarding parameters for the proper temperature range.</p> <p>The DNS stated that the first floor had not yet begun using the new temperature forms (being</p>	F 431		

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F 431	Continued From page 27  used on the second and third floors) which stated that the temperature should range between 36 and 46 degrees. The form provided a space to log the exact temperature, and a space to indicate what action was taken for temperatures outside the proper range.  The DNS stated that temperatures at or near freezing could alter the effectiveness of medications such as biologicals and that there was no way of knowing if this had occurred in the first floor medication refrigerator based on the information documented on the logs.	F 431		