

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505513	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2012
NAME OF PROVIDER OR SUPPLIER STAFFORD HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2800 SOUTH 224TH STREET, DES MOINES, WA 98198	
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F 166 SS=D	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure resident grievances were promptly acted upon for two (#s 73 and 15) of three residents reviewed for missing property. This failure prevented residents from using their own property and had the potential to cause emotional distress. In addition the facility failed to complete and/or update resident inventory lists which impaired the facility's ability to resolve grievances.</p> <p>Findings include:</p> <p>In an interview on 12/19/12 at 9:24 a.m., Staff D described the facility's Missing Property procedure. The staff member who received a report of a missing item was responsible to fill out a Lost/Missing Items Report; were to notify laundry, nursing and social services; and were to leave the report on a clipboard at the nurse's station. Staff D said she checked the clipboard daily, picked up the Reports, talked with the resident/family member to determine how long the item had been missing and began an initial search. If the item was not found, Staff D would then contact the resident/family and offer reimbursement if appropriate. Staff D said when resolved, the completed Reports were filed in a</p>	F 166	<p>The deficiency related to F-166 has been corrected in a lasting and timely manner by in servicing staff related to timely resolution of missing property. Resolution for resident's #73 and #15 has been completed. Social Services Director will monitor for compliance.</p> <p style="text-align: center;">RECEIVED JAN 15 2013 DSHS/ADSA/RCS Region 4</p>	2-1-13

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F 166	<p>Continued From page 2</p> <p>binder, however "the active ones I carry with me." Staff D said resolution of the grievance should occur within one week to 10 days.</p> <p>In addition, in an interview on 12/19/12 at 1:52 p.m. Staff C said the Personal Effects Record should be updated by the staff responsible for handling missing items. If and when staff determined an issue was resolved, that item should be reflected on the inventory list.</p> <p>RESIDENT #73 In an interview on 12/14/12 at 12:07 p.m., Resident #73's family member said when Resident #73 was moved from the second to the the third floor on [REDACTED] 12, "they lost his bottom teeth". Also missing were photos of family members which had been posted in his room and a comforter. Resident #73's family member said she reported the missing items to several staff members. The comforter was found but the resident's photos and dentures were still missing.</p> <p>On 12/17/12 at 2:22 p.m., Resident #73 was observed to be edentulous with only upper dentures in place. Resident #73 said "They got lost, they got lost" as he pointed to his lower gums.</p> <p>Review of the resident's record revealed an unsigned Personal Effects Record dated 09/13/12, which listed both upper and lower dentures but did not list either a comforter or photographs.</p> <p>Review of the Missing Items binder revealed no Lost/Missing Items Reports relating to the above items.</p>	F 166	<p style="text-align: center;">RECEIVED JAN 15 2013 DSHS/ADSA/RCS Region 4</p>

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

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F 166	<p>Continued From page 3</p> <p>In an interview on 12/19/12 at 9:24 a.m. Staff C and D said they had not been notified Resident #73 was missing dentures or family photos. Staff D stated the missing comforter "rings a bell" and said she would look at prior Missing Items Reports.</p> <p>On 12/20/12 at 12:10 p.m. Staff D provided a Lost/Missing Items Report dated 10/10/12 which listed three missing articles, "dentures - lower, quilt, and plastic pictures (family)". The listed date and time of loss was 10/09/12 A.M. Staff checked "Yes" the article was listed on the resident's clothing list. The Investigation Response noted, "Moved to (room number) last [REDACTED] 12 after lunch and NAC assigned to him sat, sun notified no dentures too. Quilt found. Action taken: Searched first floor carts and third floor carts as well as his room." There was no further action noted and no listed date of resolution. Staff D said she found the Report with the other open/active Reports.</p> <p>The facility failed to take prompt efforts to resolve the grievance regarding missing items. In addition, the facility failed to ensure the Personal Effects Record was updated to reflect the found quilt and the missing dentures.</p> <p>RESIDENT #15 In an interview on 12/14/12 at 8:01 a.m. Resident #15 said "My daughter in law bought me a nice robe and gown, but the robe's been missing." Resident #15 said she reported the item missing and indicated Staff D was "assigned to finding things". She commented, "They keep saying they're looking but they don't ever find it" and "they never replace anything."</p>	F 166			

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F 166	<p>Continued From page 4</p> <p>In an interview on 12/19/12 at 9:38 a.m. Staff D said Resident #15 regularly ordered clothes from catalogs, did not put her name in them and did not add the items to her inventory list. Staff D stated she heard about the missing robe in October and had been looking for it. She stated, "I guess we need to replace it."</p> <p>Similar findings were identified for Resident #156 who reported two rings missing. The Personal Effects Record located in her chart was signed by staff, but not dated. It was not dated or signed by the resident or her responsible party. The inventory listed two rings, but did not describe them other than to note "yellow and white". The inventory did not identify all of the clothing and personal items observed in the resident's room on 12/19/12.</p> <p>The facility investigated the missing rings and determined the resident retained possession of the rings listed on the inventory. The facility concluded "Items she claimed missing were not listed on inventory... there is nothing to validate her accusation... Action taken: closed."</p> <p>In an interview on 12/20/12 at 11:00 a.m., the Administrator explained residents often admitted with very few items and family would bring items over the next few days without notifying staff. He stated there was no process to periodically update inventory lists. Failure to ensure resident's items were accurately accounted for placed them at risk to to not have missing items returned or replaced.</p>	F 166	<p style="text-align: center;">RECEIVED JAN 15 2013 DSHS/ADSA/RCS Region 4</p> <p>The deficiency related to F-272 has been corrected in a lasting and timely manner by in-servicing the licensed nurses completing the comprehensive assessment regarding accurate coding of the MDS. Cited MDS coding examples have been corrected. The DNS and ADNS will monitor to ensure compliance.</p>	2-1-13
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS	F 272		

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F 272	<p>Continued From page 5</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:</p> <ul style="list-style-type: none"> Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. 	F 272	<p style="text-align: center; font-size: 2em; transform: rotate(-15deg); opacity: 0.5;">RECEIVED</p> <p style="text-align: center; font-size: 1.5em; transform: rotate(-15deg); opacity: 0.5;">JAN 15 2013</p> <p style="text-align: center; font-size: 1.2em; transform: rotate(-15deg); opacity: 0.5;">DSHS/ADSA/ACS Region 4</p>	
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F 272	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to accurately assess three (#s 65, 213 & 185) of three residents reviewed for dental status and two (#s 8 and 83) of three residents reviewed for skin conditions. Failure to accurately assess dental and/or swallowing status and skin conditions placed these residents at risk for unidentified and/or unmet needs.</p> <p>Findings include:</p> <p>DENTAL STATUS RESIDENT #65 On 12/17/12 at 9:26 a.m. Resident #65 was observed with only three lower right teeth. Resident #65 said "I have no teeth. I have them (dentures), but they don't fit anymore, I need a new one."</p> <p>According to the 03/14/10 Self Care Deficit Care Plan (CP), the resident had upper dentures. The 10/13/12 Nursing Care Directives indicated the resident had her "own teeth, missing several", "dentures/bridge not used", "has dentures, refuses please encourage".</p> <p>The Oral/Dental Status section of the 10/01/12 Minimum Data Set (MDS) did not indicate the resident had loosely fitting dentures, no natural teeth, or parts of teeth.</p> <p>The 10/13/12 Nursing Quarterly care plan review indicated the resident "is missing most of her natural teeth, have dentures which she has been</p>	F 272	<p style="text-align: center;">RECEIVED JAN 15 2013 DSHS/ADSA/RCS Region 4</p>	
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F 272	<p>Continued From page 7</p> <p>refusing for years now, has denied any pain or discomfort".</p> <p>In an interview on 12/18/12 at 1:28 p.m. Staff E said she completed the MDS and "I know she had dentures which she refused and so doesn't wear dentures." Staff E stated, "She'll tell you she doesn't want it, she won't give any reason, she says no discomfort."</p> <p>In an interview on 12/18/12 at 1:46 p.m. Staff F stated she would expect the MDS to have reflected the resident's dental status, in this case as having loose fitting dentures.</p> <p>RESIDENT #213 Observation of Resident #213 on 12/13/12 at 11:52 a.m. revealed her left upper tooth was chipped. According to the resident's family member at that time, the tooth was part of a bridge that had been broken for "several years".</p> <p>The Oral / Dental Status section of the 11/12/12 MDS did not identify the "broken or loosely fitting full or partial denture (chipped, cracked, uncleanable or loose)."</p> <p>According to Staff G on 12/20/12 at 9:05 a.m., she did not recall seeing a chipped partial front tooth when she conducted the resident's assessment. She acknowledged if a tooth on a bridge was chipped it should be coded. Staff G stated she would observe the resident and provide additional information if appropriate. No further information was provided.</p> <p>SWALLOWING RESIDENT #185</p>	F 272	<p style="text-align: center;">RECEIVED JAN 15 2013 DSHS/ADSA/RCS Region 4</p>	
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F 272	Continued From page 9 wound and physician's orders for the treatment and stated "that is not the feet". She stated the MDS was inaccurate as the resident did not receive treatment to her feet. RESIDENT #83 In an interview on 12/14/12 at 10:07 a.m. Staff H said Resident #83 had a Stage III pressure ulcer located on the coccyx. The 09/13/12 Nursing Assessment noted two open areas, one on the left and one on the right buttock. The assessment did not note a stage for either wound. The 09/19/12 MDS assessed the resident as having two Stage II pressure ulcers present at admission with an onset date of 09/13/12. The 12/05/12 Wound Assessment indicated the resident was "admitted with unstageable wound that when base was clean was consistent with a stage III." The 12/12/12 Wound Assessment indicated the pressure ulcer was on the resident's coccyx with an onset date of 9/12/12, prior to admit. In an interview on 12/18/12 at 2:52 p.m. Staff F said the skin sheet she obtained the data from inaccurately noted the wounds as Stage II, however the MDS should have been coded as "unstageable".	F 272	<p style="text-align: center;">RECEIVED JAN 15 2013 DSHS/ADSA/RCS Region 4</p> <p>The deficiency related to F-279 has been corrected in a timely and lasting manner by in-servicing the multi-disciplinary team to care plan development and updating. Cited examples for residents residing in the facility have been corrected. The nurses completing the MDS's will review the care plans for accuracy. The ADNS and DNS will monitor to ensure compliance.</p>	2-1-13
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's	F 279		

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F 279	<p>Continued From page 10 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 develop and/or revise comprehensive care plans for 11 of 26 sample residents (#s 69, 12, 213, 263, 150, 131, 260, 83, 186, 154 & 73) reviewed. Failure to establish care plans that accurately reflected assessed care needs related to dialysis, nutrition, communication, discharge planning, positioning and dental care placed residents at risk to receive less than adequate care.</p> <p>Findings include: RESIDENT #69 DIALYSIS Review of Resident #69's chart revealed she left</p>	F 279	<p style="text-align: center;">RECEIVED JAN 15 2013 DSHS/ADSA/RCS Region 4</p>	
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F 279	<p>Continued From page 11</p> <p>the facility three times a week to receive dialysis. The resident's diet was upgraded to mechanical soft on 12/03/12.</p> <p>Review of the resident's care plans (CP) revealed no care plan which clearly identified contact information for the dialysis agency. According to Staff H, the name of the dialysis center was taped to the wall behind the nurse's station and written on the Medication Administration Record, but was not on the CP.</p> <p>The Nutrition CP identified "provide high protein diet, maintain protein (greater than) 3.5." In an interview on 12/18/12 at 9:16 a.m. Staff H stated the resident received a renal diet. Staff H further stated the CP was "incorrect, she was not on a high protein diet". She also stated the CP did not, but should, reflect the resident's change to a mechanical soft diet.</p> <p>Staff N, the Registered Dietitian, stated Resident #69 received "a personalized high protein diet". Staff N also stated the resident "was not one to follow a renal diet". The resident's diet was not clear in the CP, as staff were unaware of the offering of high protein items and the refusal to follow a renal diet.</p> <p>According to dialysis labs dated 09/12/12, a goal was identified that the resident's albumin be at "4.0 or above". These labs also noted the resident's "dry" weight was 39.5. The comment, "your body wt when you are not carrying extra fluid. This is the wt you should be at the end of your dialysis treatment", did not have a goal weight listed. Neither the albumin level or dry weight goal were identified in the resident's</p>	F 279	<p style="text-align: center;">RECEIVED JAN 15 2013 DSHS/ADSA/RCS Region 4</p>	
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F 279	<p>Continued From page 12 comprehensive care plan.</p> <p>Observation on 12/18/12 at 11:01 a.m. revealed two band aides on the resident's upper right arm shunt site. There was no CP directive for the application or monitoring of band aids to the shunt site.</p> <p>According to Nursing Care Directives, aids were directed, "No blood pressure (bp) check to both upper arm... check bp to lower arm". The "Alteration in Genitourinary / Gynecological Status" CP directed staff "no bp or blood draw from (right) arm where shunt is." In an interview on 12/18/12 at 11:05 a.m., Staff H was unable to explain why staff were directed not to obtain a blood pressure on the left arm as "that is not where the shunt is".</p> <p>RESIDENT #12 Review of weight records for Resident #12 revealed a loss of 6.1% of his body weight between admission and 30 days after admission. Review of progress notes revealed the resident had diagnoses that included edema and c-diff. In addition, the resident received an antibiotic for sternal osteomyelitis.</p> <p>According to the Alteration in Nutrition CP, the resident had a potential for weight loss, however the actual weight loss was not identified or addressed. This CP did not identify the resident's infections as a risk factor for weight loss.</p> <p>In an interview on 12/19/12 at 2:10 p.m., Staff M stated the CP should have reflected the identified weight loss and the resident's diagnosis of c-diff as a possible contributing factor to weight loss.</p>	F 279	<p style="text-align: center;">RECEIVED JAN 15 2013 DSHS/ADSA/RCS Region 4</p>	
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F 279	<p>Continued From page 13</p> <p>RESIDENT #213 The 11/07/12 Alteration in Genitourinary / Gynecological Status CP, reviewed on 12/20/12, identified a goal that the resident's Foley catheter was to be patent and intact. Interventions included the diagnosis that required the catheter, the type of catheter in use and directions for staff to provide catheter care and check its function every shift.</p> <p>According to physician's orders, the catheter was discontinued on 12/12/12. The CP was not updated to reflect the resident's current status.</p> <p>RESIDENT #263 The 12/04/12 Alteration in Communication CP identified the resident's primary language was English. Nursing Care Directives identified the resident's primary language was something other than English and that he spoke "Some English." The 12/09/12 MDS identified the resident needed or wanted an interpreter due to his preferred language was not English.</p> <p>The 12/04/12 Discharge Planning CP did not identify barriers to the resident's discharge. It also identified a self medication program as an intervention.</p> <p>In an interview on 12/19/12 at 2:18 p.m., Staff O stated the resident was scheduled to discharge on 12/21/12. She stated he was not on a self medication program and acknowledged the barriers to discharge intervention had not been completed. She also stated while Resident #263 understood and spoke some English, it was not his primary language. Staff O acknowledged both care plans were inaccurate.</p>	F 279	<p style="text-align: center;">RECEIVED JAN 15 2013 DSHS/ADSA/RCS Region 4</p>	
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NAME OF PROVIDER OR SUPPLIER STAFFORD HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2800 SOUTH 224TH STREET, DES MOINES, WA 98198
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F 279	<p>Continued From page 14</p> <p>Similar findings were identified for Resident #150 for whom the CP directed staff to float her feet while in bed. In an interview, Staff B stated that intervention should not have been on the CP as the resident was independent with positioning.</p> <p>RESIDENT #131 Resident #131 admitted to the facility on [REDACTED] 17/12 with fractures for skilled therapy.</p> <p>The Self Care Deficit CP, dated 10/17/12, identified an intervention that the resident required two person physical assistance with transfers. Nursing Care Directives, updated 12/14/12, and the Impaired Physical Mobility / Musculoskeletal CP identified the resident transferred with modified independence assistance. A Physical Therapy note revealed the resident required contact guard assistance for transfers as of 11/27/12.</p> <p>The Self Care Deficit CP, dated 10/17/12, also identified the resident required "1:1 feed assist for meals". Nursing Care Directives noted the resident was "Independent with set up."</p> <p>Similar findings were identified for Resident #260 whose 12/10/12 Impaired Physical Mobility / Musculoskeletal CP goal was not complete and for whom interventions contradicted one another with regards to how long he was to be up in a chair.</p> <p>RESIDENT #83 According to a Wound Assessment, dated 12/12/12, Resident #83 admitted to the facility on [REDACTED] 12 with a Stage III pressure ulcer to the coccyx. This assessment also identified he</p>	F 279	<p style="text-align: center; font-size: 2em; font-weight: bold; transform: rotate(-10deg);">RECEIVED</p> <p style="text-align: center; font-size: 1.5em; font-weight: bold; transform: rotate(-10deg);">JAN 15 2013</p> <p style="text-align: center; font-size: 1.2em; font-weight: bold; transform: rotate(-10deg);">DSHS/ADSA/RCS Region 4</p>	
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F 279	<p>Continued From page 15</p> <p>developed a "superficial slit from the lower coccyx toward the gluteal area" on 12/05/12 that was a Stage II.</p> <p>The 09/13/12 Nutrition CP listed a goal of "No open skin". It did not reflect either of the resident's pressure ulcers.</p> <p>The 09/13/12 Actual Impairment of Skin Integrity CP noted the resident with an "open area" to the right buttocks. It did not clearly identify the Stage III to the coccyx and did not note the new Stage II area.</p> <p>In addition, Resident #83's Mood Problem CP, dated 09/06/12, was not updated to reflect the discontinuation of the [REDACTED] medication [REDACTED]</p> <p>Similar findings were identified for Resident #186 whose 07/29/12 Actual Impairment of Skin Integrity was not revised. The CP identified multiple abrasions, scratches and blisters. In an interview on 12/20/12 at 11:30 a.m., Staff M stated Resident #186 currently had no skin issues and the care plan should have been updated.</p> <p>RESIDENT #154 According to the Discharge Summary, Resident #154 admitted to the facility on [REDACTED] 12 with diagnoses that included a hip fracture and cancer. An 11/27/12 physician's order noted the resident would discharge to an adult family home on 11/30/12.</p> <p>The Initial Discharge Plan, dated 10/31/12, identified several barriers to discharge including ambulation, physical mobility, activities of daily</p>	F 279		
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F 279	<p>Continued From page 16</p> <p>living and strength and endurance. The 10/28/12 Discharge CP identified the goal that the resident would discharge home with his spouse. The CP did not identify any of the barriers to discharge noted on the discharge plan.</p> <p>An 11/09/12 Care Conference D/C plan noted the resident required 24 hour a day care and would either remain at the facility or discharge to an adult family home.</p> <p>In an interview on 12/19/12 at 9:38 a.m., Staff C stated the care plan should have included barriers to discharge. In addition, she stated the discharge CP should have been updated when staff determined the discharge goal had changed.</p> <p>RESIDENT #73</p> <p>In an interview on 12/14/12 at 12:06 p.m., a family member of Resident #73's stated his bottom dentures were lost at the beginning of [REDACTED] following a room move.</p> <p>Observation on 12/17/12 at 2:22 p.m. revealed the resident with no bottom teeth or dentures in place. At that time he stated, "They're lost."</p> <p>The Self Care Deficit CP, dated 09/13/12, noted the resident had upper and lower dentures that required oral care twice a day. The CP had not been updated to reflect the resident's lack of lower dentures.</p> <p>Failure to review and revise care plans to ensure they accurately reflected a resident's current status and needs placed residents at risk to not receive the care they were assessed to require.</p>	F 279	<p style="text-align: center;">RECEIVED JAN 15 2013 DSHS/ADSARCS Region 4</p>	
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F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined the facility failed to follow plans of care for one (#69) of one residents reviewed for dialysis and three (#s 8, 82 & 107) of 28 residents reviewed. The facility failed to monitor a resident who received dialysis, apply a dressing, provide specific mental health interventions and attempt non-drug interventions prior to administration of an anti-anxiety medication. These failures placed residents at risk for complications related to treatments, delayed healing, and unmet needs related to depression and anxiety.</p> <p>Findings include:</p> <p>RESIDENT # 69 Resident #69 had a diagnosis of [REDACTED] disease. According to her care plan (CP), she received dialysis every Monday, Wednesday and Friday.</p> <p>According to the undated Alteration in Genitourinary / Gynecological Status CP, staff were to "check dialysis shunt for bruit / thrill (every) shift". Review of the Medication Administration Record revealed staff checked for the bruit / thrill on only three of 53 opportunities</p>	F 282	<p>The deficiency related to F-282 has been corrected in a timely and lasting manner by in-servicing licensed nurses, social services staff and activity staff regarding providing care as directed in the plan of care. The DNS, ADNS, Activity Director and Social Services Director will monitor to ensure compliance.</p> <p style="text-align: center;">RECEIVED JAN 15 2013 DSHS/ADSARCS Region 4</p>	2-1-13
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F 282	<p>Continued From page 18</p> <p>from 12/01/12 to 12/18/12. In an interview on 12/18/12 at 11:04 a.m., Staff H stated "they are not doing it every shift, they should be checking the site every shift".</p> <p>According to the Alteration in Genitourinary Status CP, staff were directed to perform "post dialysis assessment for low BP (blood pressure), dehydration, bleeding." There was no indication in the resident's record this was done. In an interview on 12/18/12 at 11:55 a.m., Staff H stated, "It doesn't look like we are doing that."</p> <p>This CP also directed staff to "review weekly dialysis report for lab, meds, transfusion give at dialysis". Review of the resident's record revealed labs from dialysis that were performed on 12/05/12 and faxed to the facility on 12/07/12. In an interview on 12/17/12 at 2:01 p.m., Staff H confirmed there were no dialysis documents in the resident's chart after 12/05/12 although she was unable to explain why they had not been received or requested.</p> <p>Failure to consistently monitor the resident as directed in the care plans placed her at risk for complications related to dialysis and an unidentified decline.</p> <p>RESIDENT #8 Observation on 12/14/12 at 12:09 p.m. revealed Resident #8 with a loose gauze dressing on her left lower leg.</p> <p>A physician's order, dated 11/30/12, directed staff to cleanse the resident's "left lateral distal lower leg", apply medihoney and cover with gauze. December physician's orders directed staff to</p>	F 282			

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F 282	<p>Continued From page 19</p> <p>"apply farrow wrap to lower extremity, apply in" morning (0700-1000) and remove at night (1900-2200).</p> <p>In an interview on 12/18/12 at 8:25 a.m., Resident #8 motioned to a wrap at her bed side and stated, "I leave it on for eight or nine hours." She stated staff put it on for her however it was not in place at that time.</p> <p>Observations on 12/18/12 at 8:49 a.m., 10:07 a.m., 11:10 a.m. and 11:20 a.m. revealed the resident with no farrow wrap to her lower extremity.</p> <p>Observations on 12/19/12 at 8:15 a.m., 9:18 a.m., 9:45 a.m., 10:30 a.m. and 11:05 a.m. revealed the resident with no farrow wrap in place.</p> <p>Observation on 12/20/12 at 10:30 a.m. revealed no farrow wrap to the resident's leg. Failure to apply the wrap as ordered placed the resident at risk for delayed healing.</p> <p>RESIDENT #82 Review of the Preadmission Screening and Resident Review (PASRR), dated 08/30/12, revealed Resident #82 had a "mood disorder" and a Level II evaluation was required. A Level II initial psychiatric evaluation summary, dated 09/28/12, indicated the resident had [REDACTED] and [REDACTED] disorders with the following recommendations: "Environmental: ask if she would like her room decorated differently; five opportunities of outside activities. Staff approaches / training: review relaxation techniques; offer calm music and activities: enjoys crochet, games; offer these activities as</p>	F 282	<p style="text-align: center;">RECEIVED JAN 15 2013 DSHS/ADSARCS Region 4</p>	
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F 282	<p>Continued From page 20 well as others that encourage creativity."</p> <p>According to the Level II, "at the time of this interview, (resident) was having problems with [REDACTED] somatic concern, emotional withdrawal, motor retardation and tension." Service needs identified included, "(Resident) was just started on [REDACTED] medication) due to [REDACTED]. If the [REDACTED] does not seem to help decrease her level of [REDACTED] and [REDACTED] please talk (with) her primary care physician again to find out if he/she would be willing to consider a medication review. Ask if she would like to talk with a chaplain to give her the opportunity to discuss any end of life concerns that she may be having. Ask her if she would be interested in making a collage of her life to give her an opportunity to celebrate it and have something to look at frequently to help remind her of good things that have happened in her life."</p> <p>In an interview on 12/20/12 at 10:02 a.m., Staff C stated "things were offered but not documented." She explained Activity staff told her they offer activities but the resident "continuously refuses." Staff C stated the resident "didn't mention why she refuses activities."</p> <p>Staff C stated identified relaxation techniques were to "use calm voice" and provide a monthly calendar of events. Staff C stated it did not appear staff documented activities or interventions that were offered or refused. She was unable to determine if specific interventions identified in the Level II were attempted or implemented. She explained in order to determine if the recommendations in the Level II</p>	F 282	<p style="text-align: center;">RECEIVED JAN 15 2013 DSHS/ADSA/RCS Region 4</p>	
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F 282	<p>Continued From page 21</p> <p>were implemented and/or effective, staff should document attempts. Failure to implement identified interventions placed the resident at risk for isolation, boredom and unmet mental health needs.</p> <p>RESIDENT #107 The Behavior Plan, dated 11/05/12, identified Resident #107 received the [redacted] medication [redacted] due to trouble sleeping and [redacted]. Staff were directed to monitor the resident's hours of sleep, however review of the Antianxiety / Hypnotic monitor revealed this was not consistently done. For example, on eight occasions in November, staff failed to record the number of hours the resident slept on the night shift.</p> <p>The Antianxiety / Hypnotic Monitor also directed staff to offer an intervention "before offering PRN (as needed) [redacted]. Review of the November Medication Administration Record, progress notes and the Antianxiety / Hypnotic Monitor revealed staff failed to consistently record non drug interventions prior to the administration of prn [redacted]. For example, on 11/08, 11/13 and 11/18/12 staff administered [redacted] without noting non-drug interventions attempted prior.</p>	F 282	<p style="text-align: center;">RECEIVED JAN 15 2013 DSHS/ADSA/RCS Region 4</p> <p>The deficiency related to F-285 has been corrected in a lasting and timely manner by in-servicing staff related to proper procedure for PASRR 2 requirements for MI and MR. Resolution for resident's #82, #69 and #107 has been completed. Social Services Director or designee will monitor to ensure compliance.</p>	2-1-13
F 285 SS=D	<p>483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR</p> <p>A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort.</p>	F 285		

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F 285	<p>Continued From page 22</p> <p>A nursing facility must not admit, on or after January 1, 1989, any new residents with:</p> <p>(i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission;</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>(ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission--</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>For purposes of this section:</p> <p>(i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1).</p> <p>(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009.</p>	F 285	<p style="text-align: center;">RECEIVED JAN 15 2013 DSHS/ADSARCS Region 4</p>	
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F 285	<p>Continued From page 23</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review the facility failed to ensure recommendations based on Pre Admission Screening and Resident Reviews (PASRRs) were implemented for one (#82) of one residents reviewed for PASRR. Additionally, the facility failed to ensure PASRRs were updated to reflect the current status of two (#s 69 and 107) supplemental residents. These failures placed residents at risk for unmet mental health needs.</p> <p>Findings include: Refer to CFR 483.20(k)(3)(ii), F282, Services per Care Plan</p> <p>RESIDENT #82 Resident #82 was admitted to the facility on [REDACTED] 11 with diagnoses that included COPD, pneumonia, congestive heart failure and atrial fibrillation.</p> <p>The PASRR, dated 10/05/11, indicated based on diagnoses of [REDACTED] a Level II evaluation was required. The request was faxed to the PASRR office with a note that read, "res(ident) is stable."</p> <p>According to the invalidation statement, dated 10/13/11, the resident had [REDACTED] and [REDACTED] that were "stable per social services."</p> <p>Another PASRR was completed on 08/30/12 indicating the resident now had a [REDACTED] and a Level II was required. A fax to the PASRR office indicated the resident "has a Level II</p>	F 285	<p>RECEIVED</p> <p>JAN 15 2013</p> <p>DSHS/ADSA/RCS Region 4</p>	
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F 285	<p>Continued From page 24</p> <p>invalidation statement. She is stable and is being seen by (mental health services). I am requesting an invalidation statement for the additional (diagnosis) of [REDACTED]</p> <p>The PASRR agency conducted a Level II evaluation, despite the facility's request for an invalidation statement. The Level II initial psychiatric evaluation summary, dated 09/28/12, indicated the resident had [REDACTED] disorders with the following recommendations: "Environmental: ask if she would like her room decorated differently; five opportunities of outside activities. Staff approaches / training: review relaxation techniques; offer calm music and activities: enjoys crochet, games; offer these activities as well as others that encourage creativity."</p> <p>According to the Level II, "at the time of this interview, (resident) was having problems with [REDACTED] Service needs identified included, "(Resident) was just started on [REDACTED] medication) due to [REDACTED] . . . If the [REDACTED] does not seem to help decrease her level of [REDACTED] please talk (with) her primary care physician again to find out if he/she would be willing to consider a medication review. Ask if she would like to talk with a chaplain to give her the opportunity to discuss any end of life concerns that she may be having. Ask her if she would be interested in making a collage of her life to give her an opportunity to celebrate it and have something to look at frequently to help remind her of good things that have happened in her life."</p>	F 285	<p style="text-align: center;">RECEIVED JAN 15 2013 DSHS/ADS/RCS Region 4</p>	
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CENTERS FOR MEDICARE & MEDICAL SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505513	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2012
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NAME OF PROVIDER OR SUPPLIER STAFFORD HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2800 SOUTH 224TH STREET, DES MOINES, WA 98198
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F 285	<p>Continued From page 25</p> <p>In an interview on 12/20/12 at 10:02 a.m., Staff C stated "things were offered but not documented." She explained chaplain services were offered "multiple times a month, this was I believe prior to the Level II recommendations, It seems to me she has had that service." She further explained Activity staff told her they offer activities but the resident "continuously refuses." Staff C stated the resident "didn't mention why she refuses activities." There was no indication the refusals were assessed to determine if there were alternate ways to provide the interventions identified.</p> <p>Staff C stated relaxation techniques were to "use calm voice" and provide a monthly calendar of events. Staff C stated it did not appear staff documented activities or interventions that were offered or refused. She explained in order to determine if the recommendations in the Level II were implemented and/or effective, staff should document attempts. She also stated the care plan should be "specific to (the) resident". Failure to provide interventions identified in the Level II evaluation placed the resident at risk for worsening mental health issues.</p> <p>RESIDENT #69 Resident #69 admitted to the facility on [REDACTED] 12. The PASRR completed 08/31/12 identified the resident had a [REDACTED] however a Level II evaluation was not required due to anticipated 30 day care.</p> <p>In an interview on 12/20/12 at 9:21 a.m., Staff C stated Resident #69's PASRR should have been revised when staff determined, after the 09/12/12 MDS that she would remain in the facility long</p>	F 285	<p style="text-align: center;">RECEIVED JAN 15 2013 DSHS/ADSA/RCS Region 4</p>	
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F 285	Continued From page 26 term. Staff C acknowledged, "we missed that one." Similar findings were identified for Resident #107 who admitted to the facility on [REDACTED] 12. The PASRR, dated 11/05/12, indicated the resident experienced [REDACTED] however a Level II evaluation was not requested due to an anticipated 30 day stay. The resident was scheduled to discharge on 12/20/12, however she remained in the facility longer than 30 days.	F 285		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure one (#94) of two sample residents reviewed for Range of Motion who had a Restorative Nursing Program (RNP) in place and one supplemental resident (#186) consistently received services to improve and/or maintain functional range of motion. Failure to provide restorative nursing programs residents were assessed to require placed them at risk for decline in range of motion, contractures and function.	F 318	The deficiency related to F-318 has been corrected in a lasting and timely manner by in-servicing the Restorative Nursing Assistants regarding completion and documentation of established Restorative Nursing Programs. Restorative Programs will be assessed for need and efficacy on a quarterly basis along with the quarterly scheduled MDS. The ADNS or designee will monitor to ensure compliance.	2-1-13

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F 318	<p>Continued From page 27</p> <p>Findings include:</p> <p>RESIDENT #94 In an interview on 12/17/12 at 10:13 a.m., Staff H stated the resident had a contracture to the right hand and, "maybe the right foot."</p> <p>Observation on 12/17/12 at 10:14 a.m. revealed the resident had a built in roll on the right arm rest of her wheelchair but her hand was not placed on it. A splint was noted on the right foot, however no splint was noted on the resident's hand.</p> <p>The Restorative Assessment / Referral, dated 02/29/12, indicated the resident had a hand contracture and required splinting and upper extremity passive range of motion "primarily on (right) hand".</p> <p>Record review revealed no restorative summary after 7/12.</p> <p>Review of November restorative sheets revealed the resident did not consistently receive the services directed by the restorative aide sheets. In an interview on 12/19/12 at 1:01 p.m., Staff R was unable to explain why, for the month of November, the resident participated in the parallel bars only twice and the omnicycle only once.</p> <p>In an interview on 12/19/12 at 1:23 p.m., Staff M stated the former restorative director left the facility in October. Staff M stated she had been reviewing the assessed programs and attempting to determine the programs as written. She stated it had been difficult to determine what the resident was assessed to require based on previous</p>	F 318	<p style="text-align: center;">RECEIVED JAN 15 2013 DSHS/ADSA/RCS Region 4</p>	
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F 318	<p>Continued From page 28</p> <p>restorative notes. Staff M explained each resident who received an RNP should have a care plan that included measurable goals and detailed, specific interventions. In addition, a quarterly RNP review should be completed for each resident on an RNP. Staff M further explained the Care Area Assessment (CAA) should address all portions of the RNP, including goals. She acknowledged Resident #94 did not have a quarterly RNP summary, had not consistently received the program she was assessed to require, and the CAA did not address the program completely.</p> <p>In an interview on 12/20/12 at 11:02 a.m., Staff M stated the Restorative Assessment / Referral was incorrect, the resident did not have a contracture to the right hand. Staff M further stated despite the inaccurate assessment, the resident continued to require the RNP program for range of motion and strengthening.</p> <p>RESIDENT #186 In an interview on 12/13/12 at 2:25 p.m., Resident #186 stated she participated in "a restorative program. Dressing me and range of motion mostly everyday."</p> <p>The Impaired Physical Mobility care plan indicated the resident was to receive a restorative program six times a week for upper extremity passive and active range of motion. She was also noted to require splinting, which the care plan indicated she refused.</p> <p>Review of the Restorative Record for November 2012 revealed Resident #186 participated in an RNP three to five times a week, not the six she was assessed to require. There were no</p>	F 318	<p style="text-align: center;">RECEIVED JAN 15 2013 DSHS/ADSA/RCS Region 4</p>	
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F 318	Continued From page 29 documented refusals. The December 2012 Restorative Record indicated the resident received the RNP five times a week with no documented instances of refusal. The 11/07/12 Quarterly Restorative Review indicated Resident #186 received a restorative program for ambulation and active and passive range of motion. The review noted the resident participated in active range of motion exercises, the omnicycle, and ambulation. This review also noted "per restorative staff her splint program is on hold per skilled therapy orders. Restorative will continue with above exercises to help to keep her joints and muscles flexible to decrease stiffness." In an interview on 12/20/12 at 11:30 a.m., Staff M acknowledged the resident did not receive the RNP six days a week as she was assessed to require. She also stated it was unclear whether the resident refused splints or if the splints were "on hold". Staff M stated she planned to review and revise all of the restorative programs but had not yet done so.	F 318			
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was	F 364	The deficiency related to F-364 has been corrected in a lasting and timely manner by in-servicing the dietary staff on food temperature and food preferences. The Dietary Manager or designee will monitor to ensure compliance and will review with the Resident Quality Assurance Food Committee.	2-1-13	

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F 364	<p>Continued From page 30</p> <p>determined the facility failed to ensure residents received food that was served at appropriate temperatures and and palatable. Fourteen (#s 80, 104, 131, 231, 185, 15, 94, 83, 8, 93, 82, 150, 135 & 107) of the 31 residents interviewed during Stage 1 voiced concerns about the temperature, taste, or look of the food served. These failures placed all residents at risk for decreased quality of life, compromised nutritional status and weight loss.</p> <p>Findings include:</p> <p>During interviews in Stage 1, residents expressed a variety of concerns related to the food served. For example, on 12/13/12 at 2:38 p.m. Resident #80 stated food served was "sometimes it's cold, sometimes warm, never hot." On 12/17/12 at 10:08 a.m., Resident #94 stated "sometimes it's (the food) not hot... its' more on the cool side." On 12/14/12 at 8:06 a.m., Resident #15 stated the food was "cold a lot of times." She further stated "If it was hot, I'd eat it better." In an interview on 12/13/12 at 2:07 p.m., Resident #131 stated "It's bland. Very basic. Not much flavor to it." On 12/17/12 at 10:27 a.m., Resident #104 said the food was often "bland." Resident #82, in an interview on 12/17/12 at 8:34 a.m. stated the food was sometimes "cooked 'til it's mush and other things are half cooked."</p> <p>A test tray was requested during the lunch meal on 12/18/12 on the 300 unit. Temperatures taken once the last resident was served included juice at 60 degrees Fahrenheit (dF) that was barely cool and milk at 52 dF. In direct contrast to the mechanical soft meal, the pureed meat was noted to be bland and the pureed vegetable</p>	F 364	<p style="text-align: center;">RECEIVED DEC 15 2013 DSHS/ADSA/RCS Region 4</p>	
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F 364	Continued From page 31 lacked seasoning. The temperatures were shared with Staff N, the Registered Dietitian, at that time. An additional test tray was requested during the breakfast meal on 12/20/12 on the 300 unit. At 8:41 a.m. the following temperatures were noted: milk 51.1 dF; apple juice 56.2 dF; and pureed french toast 129.4 dF and bland. The regular texture french toast was noted to have a cinnamon flavor which was not discernable in the puree. Staff N, requested an additional carton of milk be delivered from the trayline. She confirmed the milk was 50 dF. In an interview on 12/20/12 at 8:49 a.m. Staff N stated the milk should be in the low 40 degree range, "like 42 to 43 degrees." Staff N stated the milk tested might have had elevated temperatures "because when they set it on the tray the milk is against the (heated) pellet."	F 364	<p style="text-align: center;">RECEIVED JAN 15 2013 DSHS/ADSA/RCS Region 4</p> <p>The deficiency related to F-412 has been corrected in a lasting and timely manner by in-servicing staff assigned to arrange dental services to ensure appointments are timely and to ensure that consent for dental treatment is signed by the person with legal authority to do so. Cited examples for residents residing in the facility have been corrected. The Medical Records Supervisor will monitor to ensure compliance.</p>		
F 412 SS=E	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by:	F 412			2-1-13

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F 412	<p>Continued From page 32</p> <p>Based on observation, interview and record review the facility failed to ensure routine dental services were provided for two (#s 65 and 185) of three sample residents reviewed for dental status and one supplemental resident (#73). This failure placed the residents at risk for inadequate nutritional intake, weight loss and gum disease.</p> <p>Findings include: Refer to: CFR 483.10(f)(2), F166, Resolve Grievances</p> <p>RESIDENT #65 In an interview on 12/17/12 at 9:26 a.m. Resident #6 said "I have no teeth. I have them (dentures) but they don't fit anymore, I need a new one." The resident was observed with only three lower right teeth to which she commented, "That's all."</p> <p>The 10/13/12 Nursing Care Directive indicated the resident had her own teeth but was missing several, had dentures/bridge that was not used, and had dentures she refused, "please encourage." The 03/14/10 Alteration in Nutrition care plan (CP) included an intervention to "encourage res(ident) to wear dentures, resident declines to wear."</p> <p>The 10/13/12 Nursing CP Quarterly Review noted the resident "is missing most of her natural teeth, has dentures which she has been refusing for years, has denied any pain or discomfort. She is on a... mechanical soft diet with thin liquids, and has not had problems with chewing or swallowing." The review did not address why the resident refused her dentures.</p> <p>Record review revealed a Dental Services</p>	F 412			

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F 412	<p>Continued From page 33</p> <p>Authorization dated 09/02/09. Review of Dental Consult notes dated 09/10/09 revealed the resident was assessed to require a cleaning, four teeth extracted, a lower partial denture and a new matching upper denture. The extractions occurred 03/01/10 and the cleaning on 08/10/10. There were no further dental visits in the resident's record nor evidence the need for new dentures was pursued.</p> <p>December 2012 physician orders noted the resident was to receive a mechanical soft diet. In addition, it was noted, "May see hygienist last seen on 8/10/10" and "May see house dentist: refused on 1/13/12."</p> <p>In an interview on 12/19/12 at 1:08 p.m. Staff P said if a resident refused dental care she reported the refusal to nursing. Staff P provided a progress note written 01/13/12 "Resident stated nothing wrong with teeth, would like to use dentures, but doesn't want to see him now. Will try again next month 2/2013." Staff P was unable to provide any indication why the resident refused to see the dentist, nor evidence the resident was offered dental services since as planned.</p> <p>RESIDENT #185 Observation on 12/17/12 at 10:12 a.m. revealed Resident #185 with broken teeth on her bottom denture. At that time, the resident acknowledged her bottom denture was broken.</p> <p>Nursing Care Directives, the 10/17/12 Nursing assessment, and the Nutrition Risk assessment all noted the resident used upper dentures but not her lower dentures. Review of the resident's comprehensive care plans revealed no specific</p>	F 412	<p>RECEIVED JAN 15 2013 DSHS/ADSARCS Region 4</p>

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F 412	<p>Continued From page 34</p> <p>Dental CP. The 10/18/12 Alteration in Nutrition CP did not identify dental problems as a risk factor.</p> <p>The 10/17/12 Nutritional Assessment identified the resident had an impaired function in ability to feed self and chewing and swallowing difficulties. The assessment noted speech therapy changed the resident's diet to puree, however it did not address her dental status.</p> <p>Review of the facility's Service and/or Goods Authorization and Receipt of Information revealed it was signed on 10/19/12 by the resident's family member to decline dental services. Further review revealed the resident was her own responsible party, and the family member who declined dental services did not have the authorization to do so.</p> <p>In an interview on 12/19/12 at 1:08 p.m., Staff P stated she had the resident's family member sign the consent as she thought she was the power of attorney. On 12/19/12 at 1:30 p.m., Staff Q stated she would have expected a referral be made to social services if the resident wanted or needed dental services and the family refused. She stated no referral had been made.</p> <p>There was no plan developed to address the resident's need for dental services.</p> <p>Similar findings were identified for Resident #73 whose dentures were reported missing by his family after a move in the facility on [REDACTED] 12. Observation on 12/17/12 at 2:22 p.m. revealed the resident had no bottom teeth. Upper dentures were noted in place, but he wore no bottom</p>	F 412		
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F 412	Continued From page 35 dentures. At that time the resident stated they were "lost." In an interview on 12/19/12 at 1:08 p.m., Staff P stated the resident was "not on the list" to be seen by the dentist. She stated typically if dentures were lost the facility would complete a missing items form and if not found, an appointment would be made for the dentist to replace the dentures. Staff P stated she was not aware the dentures were missing and so a plan was not currently in place for the resident to receive new dentures.	F 412		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425	The deficiency related to F-425 has been corrected in a lasting and timely manner by in-servicing the Licensed Nurses related to the need to clarify orders, ensure availability of medications and administer medications as ordered. The Medical Records Director or designee will monitor to ensure compliance.	2-1-13

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F 425	Continued From page 36 This LEVEL B is not met as evidenced by: Based on interview and record review it was determined the facility failed to: clarify and or follow Physician's Orders and ensure medications were available and/or administered as ordered for five of ten residents (#s 82, 158, 107, 264 & 83) reviewed for unnecessary medications, one (#69) of one residents reviewed for dialysis and two (#213 and 4) supplemental resident. These failures placed residents at risk for untreated medical conditions, pain and medication errors. Findings include but are not limited to: RESIDENT #82 Review of current physician's orders (POs) revealed the resident had an order for oxygen (O2) at 1.5 liters per minute "continuous to maintain (oxygen saturation rate of) 90-94% and no higher, Resident has CO2 retention, acidosis. Document O2 sat on liter flow; oxygen sats once (every) 24 hours in am...". Review of the November 2012 Medication Administration Record (MAR) revealed staff checked the O2 rates every shift and the resident was found to be consistently above the recommended 94%, yet was kept on 1.5 liters of oxygen. There was no evidence facility staff notified the physician regarding the elevated saturation rates, which placed the resident at risk for CO2 retention and electrolyte imbalances. RESIDENT #69 Review of November POs revealed an order for epoetin. The resident went to the hospital and	F 425			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505513	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2012
NAME OF PROVIDER OR SUPPLIER STAFFORD HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2800 SOUTH 224TH STREET, DES MOINES, WA 98198		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 425	<p>Continued From page 37</p> <p>was readmitted to the facility on [REDACTED] 12. Admission orders, dated [REDACTED] 12, did not include the epoetin.</p> <p>Review of the December MAR revealed the previous epoetin order included. In an interview on 12/17/12 at 2:45 p.m., Staff H confirmed when the resident readmitted the epoetin was not on the admission orders, however the drug was placed on the December MAR in error.</p> <p>Additionally, the resident's admission POs indicated the resident should receive Colace twice a day for constipation. This order was not transcribed to the facility's POs. Resident #69 went over two weeks without benefit of the Colace, which the physician intended she receive. According to Staff H on 12/17/12 at 2:51 p.m., "we missed that one."</p> <p>RESIDENT #158 A PO, dated 11/06/12, directed staff to administer Vitamin D 50,000 international units (iu) every week for eight weeks and then administer Vitamin D 2,000 iu every day. According to the 11/12 MAR, staff started the Vitamin D 2,000 units every day on 11/09/12 with the note, "start after vit D 50000 completed". In an interview on 12/19/12 at 2:54 p.m., Staff T stated "that looks like an error".</p> <p>Additionally, an entry on the MAR directed staff to administer "vit D 50000 IU every week x 8 weeks d/c on 11/8/12". According to the MAR, staff did not administer this medication at any time from 11/01 through 11/08/12. In an interview on 12/19/12 at 2:55 p.m., Staff T stated, "according to this it should have been administered at least</p>	F 425			

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F 425	<p>Continued From page 38 once in that time period."</p> <p>A PO, dated 09/13/12 directed staff to "repeat vit d level after 8th week due 11/08/12". This lab was not located in the resident's record. In an interview on 12/20/12 at 7:40 a.m., Staff B confirmed there were multiple transcription and administration errors related to the Vitamin D. According to the 11/05/12 lab results, the resident's Vitamin D level suggested a "relative insufficiency".</p> <p>RESIDENT #107 A 12/12 PO directed staff to administer Acyclovir five times a day for five days, for a total of 25 doses. Staff inaccurately marked the days and doses on the December MAR, indicating only 22 doses were to be given. Staff then attempted to rectify the error and marked three additional doses to be given, however the 2 p.m. dose was not marked as given. Review of the bingo card revealed 25 pills were dispensed by the pharmacy but two pills remained after the medication was completed. Failure to correctly transcribe and administer the order prevented the resident from receiving the full dose as ordered.</p> <p>In an interview on 12/20/12 at 9:17 a.m., Staff B confirmed there were issues with Resident #s 69, 107 and 158 in regard to transcription and administration of medications and the system "needed some work."</p> <p>RESIDENT #264 Resident #264 admitted to the facility on [REDACTED] 12 with POs for Oxycodone and Vicodin as needed for "pain". In addition, an order for Tylenol Arthritis as needed for "back pain" was present as well as</p>	F 425	<p style="text-align: center; font-size: 2em; opacity: 0.5;">RECEIVED</p> <p style="text-align: center; font-size: 1.5em; opacity: 0.5;">JAN 15 2013</p> <p style="text-align: center; font-size: 1.2em; opacity: 0.5;">DSHS/ADSA/RCS Region 4</p>	
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F 425	<p>Continued From page 39</p> <p>a standing order for Tylenol as needed for "mild pain".</p> <p>There was no indication when staff should administer the Oxycodone or the Vicodin. Staff noted administering the Tylenol when the resident rated her pain at a five or six on a scale of ten (12/09 and 12/10/12). On other occasions, staff administered Vicodin when the resident rated her pain at a five or six (12/12, 13, 17 and 18/12.) On one occasion staff administered Oxycodone when the resident rated her pain at a seven (12/15/12). On other occasions Vicodin was administered for pain rated a seven (12/10 and 16/12) and once when the resident rated her pain as an eight (12/15/12).</p> <p>In an interview on 12/19/12 at 1:55 p.m., Staff J stated the orders should be clarified to provide staff guidelines for when to administer which pain medication.</p> <p>RESIDENT #213 Review of the December MAR revealed an order for Alendronate to be given weekly every Wednesday. Staff noted the medication was not administered on 12/05 as ordered or 12/06 as it had not been delivered by the pharmacy. There was no notation on 12/07 or 12/08 with regards to the dose. According to the MAR, the dose was given on 12/10.</p> <p>A progress note, dated 12/09/12, indicated staff "called pharmacy re: Alendronate refill. Reports she will call back when she finds out why it hasn't been sent." There was no additional note regarding the medications.</p>	F 425	<p>RECEIVED JAN 15 2013 DSHS/ADSA/RCS Region 4</p>	
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F 425	Continued From page 40 In an interview on 12/20/12 at 10:20 a.m., Staff K located a fax that the dose was ordered on 12/03/12. The pharmacy responded the refill was not available until 12/07/12. Staff K stated at that time staff should have attempted to determine if one dose was still in the facility, possibly in another cart or on another floor, as the resident had transferred units. If the dose was not found, staff should have notified the Director of Nursing to see if a dose could be ordered early. In addition, the physician should have been notified of the medication not being administered. There was no indication any of that was done or that the pharmacy was contacted again until 12/09/12. Failure to ensure an ordered medication was available to administer resulted in the dose being given five days late. RESIDENT #4 Resident #4 had a PO for Diltiazem every six hours. The MAR directed staff to hold the dose for a heart rate less than 65. Review of the 12/12 MAR revealed staff administered the medication on several occasions when, according to the recorded heart rate, it should have been held. For example, on 12/17/12 the recorded heart rate was 62 and staff administered the dose. On 12/18/12 the heart rate was 60 and the dose was administered. On 12/11 and 12/15 the heart rate was recorded as 64 and staff administered the dose. Similar findings were identified for Resident #83 to whom staff administered Metropolol on 11/15/12 despite a recorded blood pressure at which it should have been held.	F 425			
F 431	483.60(b), (d), (e) DRUG RECORDS,	F 431	<p style="text-align: center;">RECEIVED JAN 15 2013 DSHS/ADSA/RCS Region 4</p> <p>The deficiency related to F-431 has been corrected in a lasting and timely manner by in-servicing the Licensed Nurses related to ensuring drugs and biological are labeled in accordance with accepted professional principles, stored appropriately and securely. The DNS or designee will monitor to ensure compliance.</p>	2-1-13	

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F 431 SS=D	<p>Continued From page 41</p> <p>LABEL/STORE DRUGS & BIOLOGICALS</p> <p>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.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</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:</p>	F 431	<p style="text-align: center;">RECEIVED JAN 15 2013 DSHS/ADSA/RCS Region 4</p>	
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F 431	<p>Continued From page 42</p> <p>Based on observation, interview and record review the facility failed to ensure drugs and biologicals were labeled, dated and/or disposed of when expired in accordance with currently accepted professional standards. This failure was identified on five of five medication carts and three of four medication rooms reviewed and placed residents at risk to receive expired medications.</p> <p>Findings include:</p> <p>Review of the facility's Expiration Date reference list revealed the following medications expired after the noted amount of time: Influenza and pneumococcal vaccines expired six months after opening; Tubersol (PPD) expired 30 days after opening; ophthalmics expired six months after opening and Xalatan eye drops expired six weeks after opening. The Reference List included directions that "date opened should be recorded on any product that expires before manufacturer's dating. The pharmacy administration of eye medication policy directed staff to "date the container when opened."</p> <p>In an interview on 12/19/12 at 10:27 a.m. Staff B confirmed vials of PPD, pneumovax and influenza should be dated when opened. In addition, Staff B said when a resident was discharged from the facility, the medication was removed from the medication cart and placed in the medication room return box. Staff B stated it was the facility's expectation medications be returned to the pharmacy or destroyed within seven days of the resident's discharge date.</p> <p>Observation of the 100 unit South medication cart</p>	F 431			

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F 431	<p>Continued From page 43</p> <p>on 12/13/12 at 8:45 a.m. revealed a prescription of Premarin filed on 11/10/12 for Resident #251 in the top drawer with the house supply medications. Staff I said, "I'll take that out, she is discharged." On 12/18/12 at 8:00 a.m. Medical Records staff indicated Resident #251 discharged on [REDACTED] 12.</p> <p>Observation of the 100 unit medication room on 12/13/12 at 9:11 a.m. revealed the following: A house supply of Vitamin B12 with a manufacturer's discard date of 11/12. The medication refrigerator contained a bottle of Lantus insulin inside a brown bag on which was written an opened date of 11/08 and Resident #107's name. Staff J said the Lantus was expired and should be discarded. Upon opening the bag, Staff J noted the vial still had a purple cap indicating it had not yet been opened, did not have a resident name and was house supply.</p> <p>Observation of the 200 unit medication cart on 12/13/12 at 9:00 a.m. revealed the following: Two vials of Lovenox with no name or date when opened. According to Staff K, the resident for whom the medication was intended discharged and they, "Should be gone." A bottle of Lubrifresh had a room number on it and was not dated when opened. According to Staff K, the resident's name should be on the bottle and it should be dated. Three prescription bottles of eye drops for Resident #266 were not dated when opened.</p> <p>Observation of the 200 unit medication room refrigerator on 12/13/12 at 9:30 a.m. revealed a vial of PPD solution, a vial of pneumovax and a vial of influenza vaccine, all which had been opened. None of the vials were dated when</p>	F 431			

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F 431	<p>Continued From page 44 opened.</p> <p>In addition, six acetaminophen suppositories with a manufacturer's expiration date of 10/2012 were noted. Staff K said she would have expected them to be disposed of when they expired.</p> <p>Observation of the 300 unit medication cart on 12/13/12 at 8:30 a.m. revealed the following: A bottle of Brimonidine eye drops for Resident #142 dated as opened 10/09/12. Calcitonin was noted for Resident #2 in a plastic screw top container, which was not dated when opened. The container indicated the medication was dispensed from the pharmacy on 04/30/12. There were illegible numbers written on the container but Staff O stated, "It's hard to read. It could be the room number or the date... not sure." The vial of Calcitonin was not dated. According to the policy on the cart, this medication was good for 35 days after opening. Two containers of Xalatan eye drops were noted without dates when opened, rendering staff unable to determine expiration dates. Calcitonin for Resident #112 was dated as opened on 10/13/12. In an interview on 12/13/12 at 8:35 a.m., Staff O stated, "It's expired."</p> <p>A second medication cart on the third floor contained a bottle of moisturizing eye drops which was noted open but without a resident name or date opened. In an interview on 12/13/12 at 10:05 a.m., Staff L confirmed medications should be labeled as to which resident they belong and the drops should have been, but were not, dated when opened.</p> <p>This cart contained a bottle of Timolol eye drops</p>	F 431		
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F 431	Continued From page 45 which were open and not dated. There was a bottle of eye drops for Resident #202 which was opened on 09/25/12. The manufacturer's expiration date was 10/12. According to Staff L, "that's expired". Staff L also confirmed that a bottle of Xalatan for Resident #150, which was dated as opened on 10/12/12 was expired. An insulin vial was opened and dated as 12/27. In an interview at that time, Staff L indicated medications were dated when opened and since 12/27 hadn't happened yet "maybe it's 11/27/12". Observation of the 500 unit medication cart on 11/13/12 at 9:20 a.m., revealed a bottle of eye drops which were opened and not dated. The bottle was not labeled with a resident name. In an interview at that time, Staff G stated she was unaware for whom this medication was intended and indicated the medication needed to be removed from the cart. Observation of the 500 unit medication room revealed one vial of Tubersol which was opened but not dated. This was confirmed by Staff O who indicated the Tubersol should have been dated when opened. Failure to consistently date medications prevented staff from determining when medications were expired. Failure to remove medications when expired placed residents at risk for decreased effectiveness of medications	F 431			
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514	The deficiency related to F-514 has been corrected in a lasting and timely manner by in-servicing Licensed Nurses and Medical Records Staff related to ensuring accuracy and completeness of the clinical record. The DNS, ADNS and Medical Records Supervisor will monitor to ensure compliance.	2-1-13	

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F 514	<p>Continued From page 46</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to maintain complete and accurate medical records for 14 (#s 73, 156, 249, 107, 185, 94, 260, 257, 249, 73, 15, 83, 69 & 80) of 30 sample records reviewed. Failure to ensure documents, including care plans, assessments, inventory records and medication administration records were complete, accurate and readily accessible placed residents at risk for unmet needs.</p> <p>Findings include but are not limited to: Refer to: CFR 483.10(f)(2) , F166, Resolve Grievances CFR 483.20(b)(1), F272, Comprehensive Assessments CFR 483.20(k), F279, Develop Comprehensive Care Plans CFR 483.60, F425, Pharmacy Services</p> <p>INVENTORY RECORDS In an interview on 12/14/12 at 12:06 p.m.,</p>	F 514		
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F 514	<p>Continued From page 47</p> <p>Resident #73's family member stated the resident's bottom dentures, a photo and a comforter were lost when the resident changed rooms in the facility at the beginning of October. The photo and the comforter were located by the facility, however the dentures were still missing.</p> <p>Resident #73's chart revealed a Personal Effects Inventory (PEI) dated 09/13/12 but not signed by the resident or his representative. It listed upper and lower dentures, but did not list the comforter or family photo.</p> <p>The PEI for Resident #156 was not dated or signed by the resident and not dated by the staff who completed it. The PEI for Resident #249 was not signed by either the staff or the resident and was not dated. The PEI for Resident #107, who admitted to the facility on [REDACTED] 12, listed only a watch with no description and a pair of glasses. It was not signed or dated by staff or the resident. The PEI for Resident #185 was signed and dated 10/17/12. It indicated upper partial dentures. In an interview on 12/18/12 at 2:07 p.m., Staff G stated the resident had both upper and lower dentures. She acknowledged this was not reflected on the inventory. Resident #94 was admitted to the facility in 2007. The PEI in her record was blank.</p> <p>INACCURATE DOCUMENTATION Review of Resident #260's December Medication Administration Record revealed staff noted the resident was administered Hydrocodone on two separate occasions on 12/11/12. Review of physician's orders revealed no order for Hydrocodone. According to Staff I on 12/20/12 at 10:30 a.m., she mistakenly wrote Hydrocodone when she administered Oxycodone. She</p>	F 514		
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F 514	<p>Continued From page 48 acknowledged it was a documentation error.</p> <p>Similar findings were identified for Resident #257 for whom staff documented administering "Oxycodone 5/325" on 12/14/12, but who did not have an order for Oxycodone. On 12/19/12 at 10:28 a.m., Staff J stated staff "probably" meant Hydrocodone.</p> <p>Admission physician's orders for Resident #249 included direction to staff to hold the dose of Amlodipine for a "DBP <60" (diastolic blood pressure less than 60). The order was transcribed on the November Medication Administration Record as hold for an apical pulse less than 60. Staff failed to note the error in November.</p> <p>The 09/27/12 Minimum Data Set in Resident #73's record noted a diagnosis of obesity. In an interview on 12/18/12 at 2:00 p.m., Staff G stated the MDS in the resident's chart had different data than what was transmitted electronically. She explained prior to transmission, the data was verified and as obesity was not accurate it was removed from the computerized MDS. She stated it was not corrected in the MDS that remained in the resident's chart.</p> <p>In an interview on 12/19/12 at 8:34 a.m., Staff S explained showers were documented as given in the nursing assistant book. Review of the NAC Resident Care Record for Resident #15 revealed staff failed to consistently document showers. For example, no baths were documented as given or refused in October, 2012. The record noted Resident #15 went up to nine days between showers in November and December, 2012.</p>	F 514	<p style="text-align: center;">RECEIVED JAN 15 2013 DSHS/ADSA/RCS Region 4</p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505513	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2012
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NAME OF PROVIDER OR SUPPLIER STAFFORD HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2800 SOUTH 224TH STREET, DES MOINES, WA 98198
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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 514	<p>Continued From page 49</p> <p>According to Staff S, that was not accurate. Failure to accurately record care given placed the resident at risk to not receive needed care.</p> <p>Review of numerous resident's care plans (CP) revealed staff frequently failed to date when the CP was initiated and when changes were made to it. For example, Resident #83's Alteration in Nutrition CP, originally dated 09/12/12, included handwritten updated goals and problems without date of origin or discontinuation. The Actual Skin Impairment CP for Resident #15, originally dated 09/09/11, had problems in different handwriting that were not dated.</p> <p>A Change of Diet form for Resident #69 was located in Resident #80's chart.</p>	F 514		
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JAN 15 2013
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/27/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505513	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2012
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NAME OF PROVIDER OR SUPPLIER STAFFORD HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2800 SOUTH 224TH STREET, DES MOINES, WA 98198
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F 272	<p>Continued From page 8</p> <p>Review of the resident's record revealed a 10/17/12 Nutritional Assessment which identified the resident had functional impairment with chewing and swallowing.</p> <p>A 10/11/12 Dysphagia background assessment identified the resident as having behaviors which impacted safety including "holding food in mouth/cheeks or residual food in mouth, expulsion of solids."</p> <p>A 10/22/12 Physician's Order included a pureed diet due to a diagnosis of dysphagia.</p> <p>The 10/23/12 MDS assessed the resident without signs and symptoms of a possible swallowing disorder.</p> <p>In an interview on 12/18/12 at 1:11 p.m. Staff G said "I missed that" and added the MDS should have been coded to reflect "Holding food in mouth/cheeks or residual food in mouth after meals" and a diagnosis of dysphagia.</p> <p>SKIN CONDITIONS RESIDENT #8 Observation on 12/14/12 at 12:09 p.m. revealed the resident had a dressing on her left lower leg. Review of the 11/01/12 MDS indicated the resident had application of dressing to the feet, however review of the record revealed no evidence that dressings to the feet were taking place at that time.</p> <p>In an interview on 12/18/12 at 1:14 p.m. Staff E stated she coded the MDS in reference to the dressing above the ankle. In an interview on 12/19/12, Staff M reviewed the location of the</p>	F 272		
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