

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  04/03/2014
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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 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Stafford Healthcare on 03/27/14, 03/28/14, 03/31/14, 04/01/14, 04/02/14 and 04/03/14. A sample of 19 residents was selected from a census of 92. The sample included 18 current residents, the record of one former and/or discharged residents and six supplemental residents.</p> <p>Survey team members included: Jennifer Alley, MSW Lisa Foster, RN, MN Sharon Stephens, BSN, RN Kathy Wrynn, RN, MN</p> <p>The survey team is from: Department of Social and Health Services Aging and Adult Services Administration Residential Care Facilities Region 2, Unit F 20425 72nd Avenue South, Suite 400 Kent, Washington 98032-2388</p> <p>Telephone: (253) 234-6000 Fax: (253) 395-5070</p> <p><i>Mike Ambrose</i> 4/15/14 Residential Care Services Date</p>	F 000	<p>DISCLAIMER:</p> <p>This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to Long Term Care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility. The submission of this plan does not constitute agreement by the facility that the surveyors' findings and/or conclusions are accurate, or that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied.</p> <p style="text-align: right;"><b>RECEIVED</b> APR 29 2014 DSHS/ADSA/RCS Region 4</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Kevin J. Fletcher</i>	TITLE Administrator	(X6) DATE 4/29/14
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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 159 SS=D	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the</p>	F 159	<p><b>F 159</b></p> <p>To ensure that residents have timely access to funds held in their Resident Trust account, the facility will ensure access to funds 24 hours per day/ 7 days each week.</p> <p>Residents will have access to the balance of their funds in the account. If a request exceeds \$50, the facility will provide \$50 in cash and provide the balance of the request in the form of a check drawn on the Resident Trust operating account. Resident Trust checks will be available during business office hours of Monday through Friday, 8:30 a.m. – 5:00 p.m.</p> <p>Residents will have access to Resident Trust cash (up to \$50), in one of three locations, depending on time of day. Monday through Friday from 8:30 a.m. to 5:00 p.m. in the Business Office on first floor; from 8:00 a.m. to 10:30 p.m. at the front lobby reception desk; and from 10:30 p.m. to 8:00 a.m. at the 2<sup>nd</sup> Floor nurse station. If needed, staff on 1<sup>st</sup> and 3<sup>rd</sup> floors will help residents get cash from the 2<sup>nd</sup> Floor nurse station between 10:30 p.m. and 8:00 a.m.</p> <p style="text-align: center;"><b>RECEIVED</b> APR 29 2014 DSHS/ADSA/RCS Region 4</p>	

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F 159	<p>Continued From page 2</p> <p>SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that the facility failed to provide reasonable and ready access to resident trust funds for all residents who kept funds in the trust. Failure to provide residents with ready access to the funds potentially denied those residents the right to use their funds.</p> <p>Findings include:</p> <p>According to the Resident Handbook, revised March 2014, "Resident trust funds are available at the Business Office Monday through Friday from 8:30 a.m. - 5:00 p.m.; and at the front desk 7 days a week: Monday through Friday from 8:00 a.m. - 7:00 p.m., and Saturday and Sunday from 8:00 a.m. - 4:30 p.m. Amounts requested over \$50.00 will be issued M-F as a check from the Business Office, unless prior arrangements are made."</p> <p>A sign posted at the reception desk regarding resident trust funds was observed which indicated "Resident Banking Hours, Available Daily Main Reception Desk 8:00 a.m. - 6:00 p.m."</p> <p>In an interview on 03/31/14 at 12:31 p.m. Business Office Staff O indicated residents could access their funds on a daily basis in two ways.</p>	F 159	<p>Residents will be informed of these changes through written notice and through the Resident Council. The Resident Handbook will be updated to reflect these changes to ensure residents are informed at the time of admission to the facility.</p> <p>The Business Office Manager will ensure compliance.</p>	5/20/14	

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F 159	Continued From page 3 They could either "come and see me in the business office, or the reception desk." Staff O further stated residents were "not allowed to draw out more than \$50.00 per day."  In an interview on 04/01/14 at 1:11 p.m. the Administrator, Staff A, indicated the expectation for resident access to their trust funds was, "If there is money (in their account) and they want to use it, I have to provide it to them." Staff A indicated if a resident requested funds in excess of \$50.00 a check should be written. In addition, funds should be available after 6:30 p.m. for residents to access if desired.  Failure to ensure staff understood and complied with the facility's policy on resident trust fund access placed residents at risk to not have timely access to their money.	F 159		
F 250 SS=E	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE  The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to ensure residents received podiatry care after refusals for two (#s 21 and 36) of two residents and failed to ensure residents with roommate concerns had them addressed (#s 43 & 259).	F 250	RECEIVED APR 29 2014 DSHS/ADSA/RCS Region 4	

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F 250	<p>Continued From page 4</p> <p>Additionally, the facility failed to ensure information regarding the payment of dental services was provided, which lead to one resident not receiving required services (#76).</p> <p>Findings include but are not limited to:</p> <p><b>PODIATRY SERVICES</b> <b>RESIDENT #21</b> According to the 01/26/14 Minimum Data Set (MDS), Resident #21 had diagnoses including Alzheimer's Disease and dementia and was assessed to rarely/never understand with short and long term memory problems. According to the 08/01/13 MDS, the resident demonstrated refusal of care. According to the 10/28/13 and 01/26/14 MDS assessments, the resident had no refusal of care.</p> <p>Observation on 03/28/14 at 10:20 a.m. revealed Resident #21 had fingernails that were long, approximately 1.2 centimeters (cms) past the tip of the fingers, with brown debris noted under the nails of both the left and right hand. The resident was confused and unable to answer questions about nail care.</p> <p>Observations of long soiled fingernails were made throughout the day on 03/31/14 and 04/01/14. Similar findings were noted on 04/01/14 at 10:47 a.m., 11:01 a.m. and 11:22 a.m. At 2:37 p.m., the resident was noted with fingernails that were trimmed and clean.</p> <p>Observation on 04/02/14 at 11:15 a.m. revealed Resident #21 had a significantly elongated toe nail on the left foot first toe which curved and covered half of the second toe. The toe nail of the great toe had to be lifted to visualize the top of the</p>	F 250	<p><b>F 250</b></p> <p>Residents #21 and #36 have received podiatric care for the identified issues cited.</p> <p>Prior to discharge, Resident #43 was offered and accepted the use of noise limiting headphones to aid in comfort. Resident #43 is no longer a resident in the facility.</p> <p>Resident #259 has been relocated to a different room with a compatible roommate. The resident is comfortable with this change and the family is satisfied with the resolution.</p> <p>For any clinically necessary contracted service, (i.e. optometry, podiatry, dental), nurses will communicate refusals and or barriers to care to the social services department. They will obtain assistance from family members, primary care physicians or other consulting care providers to ensure care is provided as needed.</p> <p>Licensed nurses and social services staff will be inserviced regarding the referral process that must be followed upon resident refusals of necessary clinical care or any existing barriers to care.</p>		

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F 250	<p>Continued From page 5</p> <p>second toe. The second toe nail was elongated and the third toe nail on the left foot was noted to be long and curved over the tip of the toe.</p> <p>The first toe nail on the right foot was noted to be 1.5 cms past the tip of the toe. The fourth toe on the right foot was similarly elongated, measuring, 0.7 cms past the tip of the toe. These observations were confirmed by Staff H (Resident Care Manager). According to Staff H, "Podiatry does nail care; it should be in the chart under consult... they come in once a month..."</p> <p>In an interview on 04/02/14 at 1:35 p.m., Staff G (Medical Records) indicated it was her responsibility to schedule podiatry services for residents. Staff G indicated once the resident was referred to and seen by podiatry, follow up would occur every one to three months after the initial visit. "Normally if they refuse we put them on for the next month." Staff G further elaborated, "It's just the last couple of months, they've let me know (Resident #21's) nails were bad."</p> <p>Review of Podiatry consults dated 02/27/13 indicated, "Pt refused podiatry care today." A consult dated 04/06/13 revealed, "(patient) would not allow toe nails to be cut today". Similar findings were identified for Podiatry consults dated 08/12/13, 12/07/13 and 02/28/14.</p> <p>An 11/08/13 quarterly summary progress note indicated, "(resident) was last seen by the podiatrist on 4/06/13 and refused the most recent visit on 8/12/13, see under consult." Despite clear documentation staff were aware of resident refusals of podiatry, there was no evidence to support staff did anything with the information. There was no referral to social services, no</p>	F 250	<p>Sample audits of resident records who receive consultant services will be done monthly for 90 days to ensure the solution is sustained, with a report of findings to the QAPI committee.</p> <p>The Director of Nursing and Social Services Director will ensure compliance.</p>	5/20/14	

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F 250	<p>Continued From page 6</p> <p>indication staff attempted to discern why the resident refused or identified additional interventions to ensure the resident received the podiatry services she was assessed to require.</p> <p>According to a 02/05/14 quarterly summary note, staff documented, "the podiatry was here on 8/12/13, which resident refused treatment, see under consult." Again, there was no follow up regarding if nail care needs had been met or if alternative interventions might be attempted.</p> <p>In an interview on 04/03/14 at 7:55 a.m., Staff B stated, "...I didn't find anything (in the record) that we followed up on the long nails, there is nothing in social worker notes..."</p> <p>The facility failed, through the assessment and care planning process, to identify and seek ways to support residents' individual needs. There was no evidence of social service interventions which might address the resident's needs and physical care.</p> <p><b>RESIDENT #36</b> Resident #36 was readmitted to the facility on [REDACTED] 13 with multiple medical diagnoses to include coronary artery disease (CAD), renal failure, diabetes, and hearing impairment. According to the MDS dated 12/23/13, he was unable to regularly make his needs known and was dependent on staff to meet his bathing and grooming needs.</p> <p>On 03/28/14 at 1:22 p.m., Resident #36 was observed in bed, wearing a pair of heel protectors. His toenails were thick and discolored. A review of the resident's record revealed a signed wavier, dated 06/28/13, declining podiatry</p>	F 250			

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F 250	<p>Continued From page 7 services.</p> <p>According to Staff F, the resident's Power of Attorney (POA) declined services due to the resident's toenails being painful.</p> <p>In an interview on 04/03/14, Staff M (MDS coordinator) stated she did not ask the family specifically if they wanted to have the resident seen by the podiatrist. Staff M explained, "I contact the family during my quarterly review. I usually ask if they want things to remain the same." Staff M stated she didn't routinely ask the family about services they previously declined.</p> <p>In an interview on 04/01/14 at 1:22 p.m., Staff G stated she received a request from nursing on 02/10/14, to have Resident #36 added to the list of residents to be seen by the podiatrist on his/her next visit. According to Staff G she misunderstood the request and failed to add the resident's name to list of resident to be seen in March 2014. Staff G stated Resident #36 "wasn't placed on the list to be seen until April 2014."</p> <p>There was no indication the facility attempted to address the reasons behind the refusal to be seen by podiatry, ie painful toes, which podiatry can often assist with, or that the resident's responsible party was routinely approached to ensure the resident received the care he was assessed to require.</p> <p>ROOMMATE ISSUES RESIDENT #43 According to the 01/01/14 Admission MDS, Resident #43 had diagnoses which included heart and liver disease and [REDACTED] According to this MDS, the resident was assessed to</p>	F 250	<p style="text-align: center;"><b>RECEIVED</b> APR 29 2014 DSHS/ADSA/RCS Region 4</p>	

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F 250	<p>Continued From page 8</p> <p>understand and be understood in conversation and showed no cognitive deficits. This MDS indicated the resident had trouble falling or staying asleep or sleeping too much.</p> <p>Observation on 04/02/14 at 9:17 a.m. revealed a well groomed resident sitting at the bedside speaking on a cell phone. The resident was noted to be independently ambulatory with a walker.</p> <p>Record review revealed Resident #43 had been prescribed a number of different medications for sleep since admission. When asked, in an interview on 04/02/14 at 9:19 a.m., why she wasn't sleeping at night, Resident #43 stated, "because my roommate is 92 years old and all she ever does is holler, she's got this high pitched scream, she sounds like a cat in heat... that's why I can't sleep; I am kinda heated... before this, they put me in a room on the second floor, with a woman who hollered, but she was from (another country)... I probably won't sleep in this room tonight." Resident #43 elaborated she had a history of insomnia, "...but I could go to sleep, I would read myself to sleep, listen to my music but you can't do that with somebody who is hollering...".</p> <p>In an interview on 04/02/14 at 2:43 p.m., Staff H (Resident Care Manager) stated, "yes, (Resident #43's) roommate can be loud at times." Staff H elaborated, "(the roommate), she has a kind of a yell, she doesn't verbalize, she yells out a high pitched yell, sometimes during the day or sometimes at night; if they reposition her sometimes it helps, sometimes it doesn't."</p> <p>Staff H, when asked how facility staff provide care for a resident who has insomnia related to an</p>	F 250			

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F 250	<p>Continued From page 9</p> <p>external factor (noise), replied, "There are multiple facets... having a roommate change" and "we have to work with Social Services for that, there are other things we sometimes we try, headphones, I've offered ear plugs to other people...". Staff H confirmed she had not offered earplugs to Resident #43.</p> <p>In an interview on the morning of 04/03/14, Staff I (Licensed Nurse) stated Resident #43's roommate had a behavior of, "a high pitched scream." Staff I indicated, "(roommate) is usually pretty good in the day... I know that she does (scream) more so on evening shift." Staff I clarified that evening shift "is 2:30 p.m. to 11:00 p.m."</p> <p>In an interview on 04/02/14 at 2:26 p.m., Staff D explained Resident #43 admitted to the second floor, moved to the first floor, then transferred to the third floor. Staff D indicated, "She was in a room with a (non English) speaking resident who does call out... (Resident #43) was complaining of the roommate on the second floor occasionally calling out or making noise." Staff D verbalized an awareness that, "there was an issue with the roommate (on the third floor) regarding noise a couple of days after she (moved in)... in the progress notes there should be something from (Staff N) that she has offered (Resident #43) several options, I offered her today, wireless headphones; I know that traditionally we would offer earplugs or headphones or background noise..."</p> <p>Record review revealed a Social Service note dated 03/21/14 which indicated, "Writer went back up today to speak with (Resident #43) about offering her ear plugs, a fan or head phones to</p>	F 250			

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F 250	<p>Continued From page 10</p> <p>her TV so that it would minimize the screaming and screech coming from her roommate but (Resident) had already left... Writer will go see her on Monday 3/24/14 to talk about these options."</p> <p>In an interview on 04/02/14 at 3:23 p.m., Staff D confirmed Social Services staff did not follow up with Resident #43 about her complaints about the roommate making noise/keeping her from sleeping. There was no indication in the record facility staff identified the roommate as a possible contributing factor to Resident #43's insomnia, offered a room change or any intervention which might address the presenting issue. Staff D confirmed that 04/02/14 was the first offer of any intervention regarding complaints about Resident #43's loud roommate.</p> <p>Failure to provide interventions for identified factors impacting Resident #43's insomnia caused Resident #43 to feel disregarded and experience continued lack of sleep.</p> <p>RESIDENT #259 Similar findings were identified for Resident #259. Resident #259 was identified as currently sharing a room with the resident on the second floor Resident #43 had previously voiced concerns about regarding calling out at night. In an interview on 03/28/14 at 9:58 a.m., Resident #259 was observed sitting in a wheelchair outside her room. Her roommate was in the room, yelling out. Resident #259 stated, "Why is she yelling? I wish she'd stop. She is always yelling. I can't understand a word she is saying, is she asking for help?"</p> <p>Record review revealed Resident #259 received</p>	F 250	<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;">APR 29 2014</p> <p style="text-align: center; font-size: 1.2em; transform: rotate(-15deg); opacity: 0.5;">DSHS/ADSA/RCS Region 4</p>	

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F 250	<p>Continued From page 11</p> <p>██████████ as needed for sleep. The medication was administered on 13 nights in March 2014. While her care plan included an intervention for sleep of "quiet environment", it did not include any interventions specifically related to the noise her roommate made, despite the facility's awareness that the roommate called out and had been a concern for at least one prior resident. There was no indication the facility spoke to Resident #259 about her difficulty sleeping or attempted any interventions other than a sleep aide.</p> <p><b>DENTAL SERVICES</b> <b>RESIDENT #76</b> Resident #76 was a long term care resident of the facility. A 07/12/13 dental screen indicated the resident accepted to be screened and was noted with lower natural teeth, lower removable partial denture, upper complete dentures, caries (tooth decay), Periodontitis (gum disease) and xerostomia (dry mouth). The dentist recommend a diagnostic exam and a dental hygienist referral. A progress note written by Staff G on 09/23/13 indicated "House dentist sent out consents 08/08/13 to see if family wants services." A 09/25/13 progress note indicated "House hygienist sent our authorizations for cleaning 09/23/13."</p> <p>A 10/17/13 Physician's Order (PO) instructed staff to "Use dentures adhesive every day shift for to facilitate mastication". A 10/31/13 PO indicated a "Referral to hygienist - per DPOA pending approval authorization."</p> <p>An 11/13/13 dental screen noted denture sores/tissue irritation and recommended a diagnostic exam, adjust dentures and referral to dental hygienist for cleaning. An additional PO</p>	F 250	<p style="text-align: center;"><b>RECEIVED</b> <b>APR 29 2014</b> DSHS/ACSA/FCS Region 4</p>	

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F 250	<p>Continued From page 12 was written on 01/18/14 to "Adjust dentures and diagnostic exam".</p> <p>In an interview on 04/01/14 at 1:28 p.m. Staff F indicated the Alteration in Nutrition Care Plan had been updated on 11/13/13 with the added interventions of "diagnostic exam, dentures adjustment, and dental hygienist referral." Staff F was not aware if the care plan had been implemented and referred to Staff G who does the dental scheduling.</p> <p>In an interview on 04/01/14 at 1:55 p.m. Staff G said there were staff changes and they had to get authorizations for the new dental hygienist. Staff G said Resident #76 had not been seen by either dental hygienist because they were waiting for authorization from the resident's family.</p> <p>Review of notes from the dental office, provided to the facility upon request, revealed on 12/04/13 the dental staff discussed with the resident's family the recommended services and the family indicated she needed to "look into how can afford (the services)."</p> <p>A 12/12/13 dental treatment plan listed the results of the dental screen, "The following signs of oral disease or injury were observed: gingivitis (gum disease), caries (tooth decay) and ill fitting dentures causing soft tissue irritation and sores." In addition the following, "We recommend the following initial care: complete dental examination \$135.00, house call fee \$110.00, adjust dentures \$50-250 (each unit), Total \$345-745.00. All treatment will be provided on site at the facility using mobile dental appointment. (Dentist) does not accept state (Medicaid) or private dental insurance." At the bottom of the form was the</p>	F 250	<p style="text-align: center;"><b>RECEIVED</b> <b>APR 29 2014</b> <b>DSHS/ADSA/RCS Region 4</b></p>	

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F 250	<p>Continued From page 13</p> <p>options to accept or decline the treatment plan. No signature was present on the form.</p> <p>In an interview on 04/02/14 at 10:19 a.m. Staff M read a 02/14/14 progress note in which she wrote "Dental screening was done with recommended treatments sent to daughter, has not yet approved, had declined dental services on admission." Staff M commented the dentist, "wants the family to authorize (the services) because most of the money comes out of pocket."</p> <p>In an interview on 03/28/14 at 12:51 a.m. Resident #76's representative said Resident #76's "dentures are loose. I have to talk with DSHS to see if they would cover it, that's what I was told." Resident #76's representative indicated the house dentist made recommendations for dental care, but she would have to pay for any services because the dentist does not bill insurance. About a month ago, "I asked (Staff R) if there was another way and she took me to another department (in the facility) and she said I had to call DSHS because (Resident #76) is on Medicaid (DSHS)... I haven't called yet."</p> <p>In an interview on 04/02/14 at 11:03 a.m., Staff R said "She came in and talked to me about it and I took her to Staff G and left."</p> <p>In an interview on 04/02/14 at 10:49 a.m. Staff G confirmed the house dentist did not accept Medicaid funds. Staff G indicated if a resident on Medicaid was assessed to need dental care said she would refer the resident/resident representative to Social Services. Additionally, Staff G said she would try to locate a dentist for the resident to see who accepted Medicaid. Staff</p>	F 250	<p style="text-align: center;"><b>RECEIVED</b> <b>APR 29 2014</b> <b>DSHS/ADSA/RCS Region 4</b></p>	

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F 250	Continued From page 14 G said she was not aware Resident #76 was on Medicaid and had not referred her to Social Services or looked for an alternate dentist.  In an interview on 04/02/14 at 10:57 a.m. Staff D indicated the dental process was handled by Staff G, and "If there was a problem that a resident was not getting services for whatever reason, I would need to be notified." Staff D confirmed she had not been notified, nor was there a progress note indicating another social service staff was aware Resident #76's needed assistance in obtaining dental care.	F 250		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS  The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Contenance; Disease diagnosis and health conditions; Dental and nutritional status;	F 272	<p style="text-align: center;"><b>RECEIVED</b> APR 29 2014 DSHS/ADSA/RCS Region 4</p>	

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F 272	<p>Continued From page 15</p> <p>Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to accurately assess one (#22) of one sample residents and six (#s 74, 125, 170, 93, 46 &amp; 32 ) of seven supplemental residents reviewed for PASRR. In addition, the facility failed to accurately assess one (#76) of three sample residents reviewed for dental. Failure to ensure accurate assessments placed residents at risk for unidentified and/or unmet needs.</p> <p>Findings include:</p> <p>RESIDENT #22 Resident record review revealed an 11/18/10 Preadmission Screening and Resident Review (PASRR) Level I assessment that indicated the resident had mood and anxiety disorders and required a Level II evaluation. The 12/02/10 Level II evaluation listed recommendations for services,</p>	F 272	<p><b>F 272</b></p> <p>Corrections to the MDS Section A1500 PASRRs have been made for residents #22, #74, #125, #170, #93, #46, and #32 to reflect accurate assessment data.</p> <p>Resident #76 has been scheduled for a dental service appointment to resolve ill-fitting dentures. The MDS has been corrected to reflect loose dentures.</p> <p>All residents are at risk for having unidentified and/or unmet needs if correct assessments and accurate MDS coding are not provided. Social services staff will audit resident charts to ensure that accurate MDS Section A1500 PASRRs are in place for all residents.</p> <p>Sample audits of resident records who receive consultant services will be completed monthly for 90 days to ensure the solution is sustained. Findings will be reported to the QAPI Committee.</p> <p>Social Services staff will be inserviced on the correct coding of the MDS in regards to Section A1500 PASRRs. MDS nurses will be inserviced regarding correct coding of MDS assessments. When gathering information and assessing residents, conflicting data will be resolved to ensure accurate reflection of the resident's condition to ensure appropriate clinical care is provided.</p>		

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F 272	<p>Continued From page 16 including psychiatric medication evaluation/management for depression/anxiety, environmental accommodations and activities.</p> <p>Review of the 04/20/13 annual Minimum Data Set (MDS), revealed a negative response to section A1500 PASRR, indicating the resident was not considered by the state Level II PASRR process to have a serious mental illness. The erroneous response disabled the subsequent question A1510 so it was not answered affirmatively as indicated. Review of the 05/07/12 Annual MDS revealed an incorrect assessment as well.</p> <p>In an interview on 04/02/14 at 10:30 a.m. Staff M said that section of the MDS was the responsibility of Social Services staff. She further explained it had been completed by a staff member who was no longer employed by the facility.</p> <p>The facility provided a list of seven additional residents who were assessed to require a Level II evaluation and had an Admission/Annual MDS assessment. The MDS section A1500 were incorrectly coded for the following: Resident #74's 09/11/13 MDS; Resident #125's 01/15/14 MDS; Resident #170's 07/06/13 MDS; Resident #93's 11/06/13 MDS; Resident # 46's 10/06/13 MDS and Resident #32's 09/01/13 MDS.</p> <p>In an interview on 04/02/14 at 10:45 a.m. Social Services, Staff D, indicated the MDS should be answered 'yes' when the PASRR indicated the resident needed a Level II evaluation.</p> <p>RESIDENT #76 In an interview on 03/28/14 at 12:51 p.m. Resident #76's representative indicated the</p>	F 272	<p>The Social Services Director will randomly audit PASRRS of 10% of newly admitted residents over 90 day period to ensure correction is sustained ongoing. Results will be reported to the Quality Assurance Performance Improvement (QAPI) Committee. The Assistant Director of Nursing will randomly audit 10% of MDSs to ensure accurate coding regarding dental issues.</p> <p>The Director of Nursing will ensure compliance.</p>	5/20/14	

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F 272	<p>Continued From page 17 resident's dentures were loose.</p> <p>Review of the resident's record revealed an 11/13/13 dental screen note which indicated the resident had denture sores/tissue irritation and recommended "adjust dentures." A 12/12/13 dental treatment plan recommended by the dentist noted "The following signs of oral disease or injury were observed : gingivitis (gum disease), caries (tooth decay) and ill fitting dentures causing soft tissue irritation and sores". Listed recommendations included "adjust dentures".</p> <p>On 01/18/14 a physician's order followed to "Adjust dentures and diagnostic exam".</p> <p>In an interview on 04/02/14 at 10:19 a.m. Staff M read from 02/14/14 MDS related notes "wears upper and lower partial dentures with no problem. Dental screening was done with recommended treatments sent to daughter, has not yet approved, had declined dental services on admission...". After further review of the dental recommendations, Staff M said, "I should have coded loose dentures".</p>	F 272		
F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p>	F 309		

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F 309	<p>Continued From page 18</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to ensure services were provided to five of 16 residents assessed to require them. Failure to ensure a dietary consultation and recommendations were implemented in a timely manner (Resident #259), a fluid restriction was adhered to and a supplement administered as ordered (#118), that nail care (#21) was provided as required and that resident's bowel needs were consistently met (#s 191 &amp; 146) placed residents at risk for unmet needs.</p> <p>Findings include:</p> <p>Refer to CFR 483.15(g)(1), F-250, Social Services</p> <p>RESIDENT #259 Review of the Minimum Data Set (MDS) assessment, dated 02/22/14, revealed Resident #259 admitted to the facility with diagnoses to include pneumonia, anemia and hypernatremia. She was assessed to have difficulty or pain with swallowing and choking or coughing when swallowing.</p> <p>A physician's order (PO), dated 02/17/14, requested the "Dietician please consult re malnutrition." A second PO, dated 02/21/14, again requested a "Dietary consultation - protein cal(orie) malnutrition". The physician's progress note, dated 02/17/14, indicated the resident had dysphagia and severe protein and calorie malnutrition.</p> <p>The initial dietary assessment was dated</p>	F 309	<p><b>F 309</b></p> <p>At the time of State Survey, Resident #259 had had the increase in her Ensure supplement as recommended.</p> <p>Licensed nursing staff will be inserviced regarding follow through with Dietary recommendations in a timely manner.</p> <p>Resident #118 has discharged from the facility.</p> <p>Licensed nurses will be inserviced regarding the need to adjust the start and stop times in the computer when a medication is delayed in arriving from the pharmacy. This will ensure all prescribed doses are administered.</p> <p>Resident #118 had been on fluid restriction, and the fluid amount for a three day period had exceeded the amount of the ordered restriction.</p> <p>Licensed nurses will be inserviced to the practice that the nurse totaling the 24-hour fluid intake will notify the physician if the prescribed intake amount is exceeded.</p> <p>Resident #21 has received Podiatric care to resolve the cited issue.</p> <p>Licensed nurses will be inserviced to ensure the Charge Nurse is notified any time a resident refuses nail care.</p>		

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F 309	<p>Continued From page 19</p> <p>02/28/14. It identified "increased nutrition needs r/t medical repletion secondary to medical conditions requiring hospitalization and ETOH abuse. On supplemental micronutrients... Agreeable to more supplements but given wt gain would encourage evaluation with prealbumin prior to increased supplements as albumin likely falsely low r/t recent infection. Plan: Add prealbumin next lab draw. If low increase Ensure to 240cc (four times) daily."</p> <p>The resident's prealbumin was drawn on 03/04/14. The value was reported as low at a 6, with a reference range of 20-40. Despite the significantly low prealbumin level, the resident's Ensure was not increased until 03/28/14, more than three weeks after the lab draw.</p> <p>In an interview on 04/02/14 at 1:29 p.m., Staff J stated the facility's dietician kept her own schedule. She was unsure whether the facility had a way to communicate a physician's order that a consultation occur to the dietician. Staff J indicated the facility waited for the dietician to see Resident #259 after her admission like they would any other new admission. She further explained if the dietician wanted the Ensure increased she would have to write it on the MD communication sheet as the facility did not read the RD notes to see recommendations. Staff J stated she was unsure if that had happened and was missed by the physician or if the RD failed to do so and wrote the request on her next visit of 03/24/14. Staff J acknowledged there was a delay in the dietary consultation and the increase in supplement.</p> <p>RESIDENT #118 Review of a PO, dated 03/14/14, revealed staff</p>	F 309	<p>All residents will have documentation of bowel activity by nursing assistants and licensed nurses that enables accurate assessment and treatment as required.</p> <p>Licensed nurses will receive inservice training regarding the importance of accurate recording of bowel movements in the computer that reflects data submitted by nursing assistants.</p> <p>The Assistant Director of Nursing (ADNS) will audit to ensure dietary recommendations, medication start and stop times, and fluid restrictions are followed through as either recommended or ordered. Additionally, the ADNS will monitor to ensure that necessary nail care is provided.</p> <p>Medical Records staff will audit bowel records to ensure accuracy between the nursing assistant documentation of B.M.s and the computer documentation of B.M.s</p> <p>The Director of Nursing will ensure compliance.</p>	5/20/14

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F 309	<p>Continued From page 20</p> <p>were to administer a Potassium and Sodium Phosphates Solution Reconstitution two times a day for three days. Review of the March Medication Administration Record (MAR) revealed on the first two scheduled administration times, 03/14 and 03/15, staff documented the supplement had not been delivered from the pharmacy and so was not administered. Staff then noted four doses were administered and the supplement was discontinued.</p> <p>In an interview on 04/02/14 at 1:40 p.m., Staff J explained the nurses should have added two extra shifts to the electronic MAR, but failed to do so. Therefore, the PO was not followed and only four doses instead of six were administered.</p> <p>Review of the resident's initial admission PO revealed an order, dated 02/09/14, that instructed the resident receive a fluid restriction of 2000 milliliters a day. Review of the 24 hour Intake and Output record indicated on three (02/16, 17 and 20/14) of 11 days the resident consumed more than 2000 ml. Review of the resident's record revealed no indication staff notified the physician, or addressed the issue of the resident's not adhering to the fluid restriction as ordered.</p> <p>In an interview on 04/02/14 at 1:36 p.m., Staff J acknowledged the fluid restriction had not been followed as ordered on three days. She explained night shift calculated the totals, but she was not sure they passed along the information or that they looked when their shift began to determine how much the resident could drink that shift to still remain within the restriction limits. She acknowledged there was no indication staff discussed the risks of exceeding the fluid restriction with the resident. There was no</p>	F 309		

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F 309	<p>Continued From page 21</p> <p>indication the facility had a system in place to ensure the resident received the care she was assessed to require as it related to a fluid restriction.</p> <p><b>RESIDENT #21</b> According to the 01/26/14 MDS, Resident #21 had diagnoses including Alzheimer's Disease and dementia and was assessed to rarely/never understand with short and long term memory problems. According to the 10/28/13 and 01/26/14 MDS assessments, the resident had no refusal of care and required extensive one person physical assistance with personal hygiene.</p> <p>Observation on 03/28/14 at 10:20 a.m. revealed Resident #21 had fingernails that were long, approximately 1.2 centimeters (cms) past the tip of the fingers, with brown debris noted under the nails of both the left and right hand. The resident was confused and unable to answer questions about nail care.</p> <p>Observations of long soiled fingernails were made throughout the day on 03/31/14 and 04/01/14. Observation on 04/02/14 at 11:15 a.m. revealed Resident #21 had a significantly elongated toe nails on both the right and left feet.</p> <p>In an interview on 04/03/14 at 8:31 a.m., Staff F indicated shower aides were to provide nail care to residents who were not diabetic and shower aides should report to the charge nurse or Licensed staff in the event they are unable to perform nail care. Staff F further indicated that Licensed Nurses, during their weekly skin assessments, were responsible to identify any issues with long nails. Review of the past four months of weekly skin assessment notes</p>	F 309			

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F 309	<p>Continued From page 22</p> <p>revealed no noted issues with long nails. When asked when she was made aware that Resident #21's nails were significantly elongated Staff F replied, "This past weekend, I checked the nails... somebody should have told me, the bath aide, the weekly skin assessment, if there is any problem and if the resident refused they should document it, somebody should have noticed before I noticed..."</p> <p>In an interview on 04/03/14 at 7:55 a.m., Staff B stated, "...I have talked to my bath aides about reporting long nails, I didn't find anything (in the record) that we followed up on the long nails...". Staff B confirmed facility staff should have provided nail care, and in the event they were unable to do so, should have reported it to the appropriate staff (Charge Nurse, Licensed Nurse) so further action could be taken. Failure to ensure nail care was provided placed Resident #21 at risk for skin tears and had the potential to detract from the resident's sense of well being.</p> <p><b>BOWEL PROTOCOL</b> When asked for the facility's bowel protocol, Staff B provided a written explanation that the facility had "no formal protocol. Nurses to monitor BM's (bowel movements). If no BM q (every) 2-3 days to take further action."</p> <p><b>RESIDENT #191</b> Record review revealed Resident #191 received a Dulcolax suppository on 03/13/14 at 12:12 a.m. According to the MAR bowel monitor, the resident had a medium bowel movement (BM) on the previous two night shifts, questioning the need for the suppository. The resident received a Dulcolax suppository at 11:54 p.m. on 03/16/14. According to the MAR BM monitor, the resident had a</p>	F 309		
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F 309	<p>Continued From page 23</p> <p>medium BM on the day shift of 03/16/14, questioning the need for the 03/16/14 suppository.</p> <p>Review of March 2014 MAR BM monitors revealed the resident went 12 shifts without a BM from 03/22 through 26/14 with no intervention. Review of the same time period on the Nurses Aide BM record revealed the resident had multiple BMs during that period.</p> <p>Record review revealed Resident #191 received a Dulcolax suppository on 02/17/14 at 7:12 p.m. According to the MAR bowel monitor, the resident had no BM on 02/15/14 or 02/16/14, but had a small BM on day shift of 02/17/14. Review of the Nurses Aide BM indicated the resident had a small BM on day shift on 02/15, 16 and 17. In an interview on 03/31/14, Staff B was unable to explain why there was a discrepancy between bowel records.</p> <p>According to the February 2014 MAR BM monitor, the resident had no BM all day on 02/22, 23, 24, 25 nor on day shift on the 26th (four plus days), but the resident did not receive an as needed bowel medication. According to the Nurses Aide BM record the resident had small BMs on 02/22 and 02/24/14. An illegible entry was noted for the evening shift on 02/23/14.</p> <p>In an interview on the morning of 04/01/14, Staff B was unable to explain why there was a discrepancy between the MAR BM monitoring and the Nurses Aide BM monitoring or why Resident #191 received as needed bowel medication when staff had documented the resident had a BM.</p>	F 309			

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F 309	Continued From page 24 RESIDENT #146 Similar findings were identified for Resident #146 for whom record review of February, March and April 2014 MARs and bowel monitors revealed staff inconsistently administered as needed suppositories.	F 309		
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.  This REQUIREMENT is not met as evidenced by:	F 329		

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F 329	<p>Continued From page 25</p> <p>Based on observation, interview, and record review it was determined that the facility failed to ensure two of six residents (#s 43 &amp; 259) reviewed for unnecessary medications were free of unnecessary medications related to adequate indications for use, use of non-pharmacological interventions prior to the use of an as needed psychotropic medication and consistent monitoring of medication effectiveness. These failures placed residents at risk to receive unnecessary medications.</p> <p>Findings include but are not limited to:</p> <p>Refer to CFR 483.15(g)(1), F-250, Social Services</p> <p><b>RESIDENT #43</b> According to the 01/01/14 Admission Minimum Data Set (MDS), Resident #43 had diagnoses which included heart and liver disease and [REDACTED] According to this MDS, the resident was assessed to understand and be understood in conversation and exhibited no cognitive deficits. This MDS indicated the resident had trouble falling or staying asleep or sleeping too much. While a 12/31/13 progress note indicated the resident, "feels depressed and has trouble falling and staying asleep" there was no further assessment as to what specific factors might be impacting the resident's ability to sleep or what sleep hygiene techniques had historically been effective for this resident.</p> <p>Observation on 04/02/14 at 9:17 a.m. revealed a well groomed resident sitting at the bedside speaking on a cell phone. The resident was noted to be independently ambulatory with a walker.</p>	F 329	<p><b>F329</b></p> <p>Resident #43 was discharged from the facility prior to the completion of State Survey.</p> <p>Resident #259 has had non-pharmacological interventions added to her Medication Administration Record (MAR).</p> <p>Licensed nurses will be inserviced regarding the required assessment of factors that may be contributing to a resident's insomnia and/or anxiety, or any other symptoms/behaviors, and will employ non-pharmacological interventions to mitigate such factors prior to administering psychotropic medications or requesting orders for PRN psychoactive medications from the primary care physician.</p> <p>Licensed nurses will be inserviced regarding the need to ensure that non-pharmacological interventions are documented in the computer when a resident has a new PRN order for an antianxiety agent or psychoactive medication intended to promote sleep.</p> <p>The Assistant Director of Nursing will review all new orders for PRN psychoactive medications and their use. She will review the E-MAR to ensure that non-pharmacological interventions are identified for the resident.</p> <p>The Director of Nursing will ensure compliance.</p>	5/20/14	

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F 329	<p>Continued From page 26</p> <p>Record review revealed Resident #43 had been prescribed a number of different medications for sleep since admission. When asked, in an interview on 04/02/14 at 9:19 a.m., why she wasn't sleeping at night, Resident #43 stated, "because my roommate is 92 years old and all she ever does is holler, she's got this high pitched scream, she sounds like a cat in heat... that's why I can't sleep..."</p> <p>In interviews on 04/02/14 and 04/03/14, Staff H (Resident Care Manager) and Staff I (medication nurse) both indicated Resident #43's roommate could be loud at times and had a kind of high pitched yell.</p> <p>In an interview on 04/02/14 at 2:26 p.m., Staff D (Social Work staff) verbalized an awareness that, "there was an issue with the roommate (on the third floor) regarding noise a couple of days after she (moved in on 03/18/14)...". Record review revealed a Social Service note dated 03/21/14 which indicated, "Writer went back up today to speak with (Resident #43) about offering her ear plugs, a fan or head phones to her TV so that it would minimize the screaming and screech coming from her roommate but (Resident) had already left... Writer will go see her on Monday 3/24/14 to talk about these options."</p> <p>Facility staff failed to offer interventions regarding the identified loud roommate and Resident #43 was subsequently prescribed an additional sleeping medication on 03/21/14 secondary to complaints of insomnia. Failure to identify, address and eliminate or reduce underlying causes impacting the resident's ability to sleep contributed to the use of unnecessary drugs.</p>	F 329		
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F 329	<p>Continued From page 27</p> <p><b>ANTI-ANXIETY MEDICATIONS</b> Review of March 2014 Medication Administration Records (MARs) revealed Resident #43 received Hydroxyzine (anti-anxiety medication) 50 mgs regularly scheduled every night from 03/11 through 30/14 for insomnia. According to the 2012 Beers criteria for potentially inappropriate medication use in older adults, Hydroxyzine has a "high quality of evidence" to be avoided in older adults as it is "highly anticholinergic, and "tolerance develops when used as hypnotic, increased risk of confusion... and other anticholinergic effects/toxicity."</p> <p>On 03/21/14 the resident's physician documented, "has questions about sleeping pills and were answered. Willing to try Triazolam (anti-anxiety/benzodiazepine medication) as the insurance company will only pay for so many Ambien... will... add Triazolam." There was no documented assessment of the effectiveness of the routine Hydroxyzine for sleep, nor was there clinical rationale for the benefit of, or necessity for, the use of multiple medications for sleep.</p> <p>According to clinical practice guidelines, (2012 Beers criteria), "older adults have increased sensitivity to benzodiazepines... all benzodiazepines increase risk of cognitive impairment, delirium, falls fractures... in older adults..." and "Avoid benzodiazepines (any type) for treatment of insomnia...".</p> <p>A 03/09/14 nursing progress note indicated, "Resident approached nursing cart this shift inquiring about her sleeping medication. Informed her that she has Hydroxyzine ordered for insomnia.... Asked if she was aware that she had been asleep during the day for long intervals.</p>	F 329			

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F 329	<p>Continued From page 28</p> <p>Resident unable to confirm how long she had been asleep today."</p> <p><b>INACCURATE/INCOMPLETE MONITORING</b> According to the 03/14 MARs, Resident #43 received as needed Hydroxyzine for sleep on 03/02, 03, 05, 07, 08, 09/14. However, review of Target Behavior (TB) monitors for insomnia indicated the resident didn't experience insomnia on any of these days. Failure to ensure adequate monitoring of target behaviors detracted from staff's ability to track and trend effectiveness of medications.</p> <p>According to Physician's Orders, the Hydroxyzine was changed to a regularly scheduled medication, to be given every night for sleep on 03/11/14. The resident received regularly scheduled Hydroxyzine for insomnia, as well as needed Triazolam for insomnia on 03/22, 23, 24, 25, 26, 27, 28, 29, 30/14. Target behavior review revealed the resident did not experience insomnia on 3/22, 23, 24, 28, 29 or 30.</p> <p>Further review of 03/14 MARs revealed staff were directed to offer interventions prior to the administration of as needed anti-anxiety medications for anxiety, but not for sleep. As a result, facility staff failed to provide non-drug interventions (NDI) prior to the administration of as needed sleeping medication. Failure to implement non-pharmacological approaches for the resident prior to and/or in conjunction with the use of medication constituted the use of an unnecessary drug.</p> <p>Similar findings were identified when as needed Clonazepam for anxiety was administered on 03/27, 28, 29 and 30/14 but staff documented on</p>	F 329			

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F 329	<p>Continued From page 29</p> <p>the TB record no anxiety was demonstrated which required the use of the medication.</p> <p>The care plan indicated the resident had insomnia and a goal of sleeping 5-6 hours each night. The interventions identified were "Encourage optimal sleep hygiene, quiet environment, limit caffeine after 4 pm, lights off at bedtime, must limit naps to 30 mins during the day."</p> <p>While staff recorded the number of hours Resident #43 slept each shift, there was no assessment of the data. The sleep monitor for March 2014 reflected the resident slept anywhere from zero to six hours of sleep on day shift, zero to four hours of sleep on evening shift and three to seven hours at night. Failure to assess the resident's sleep patterns and follow the care plan limiting naps to 30 minutes during the day, detracted from staff's ability to determine effectiveness/continued need of the multiple medications administered for sleep.</p> <p>In an interview on 04/02/14 at 1:52 p.m., Staff C confirmed when the Hydroxyzine was ordered every night for insomnia, there was no indication of reassessment of why the resident was not sleeping. Additionally, Staff C confirmed facility staff did not document NDI prior to each as needed medication. Staff C confirmed the presence of TB monitors for sleep and anxiety but directions for staff regarding NDI were only identified for anxiety. Staff C stated, "It is confusing looking at it, we would certainly want to clarify it."</p> <p>RESIDENT #259 Review of Resident #259's record revealed a PO,</p>	F 329			

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

PRINTED: 04/08/2014  
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  04/03/2014
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 329	<p>Continued From page 30</p> <p>dated 02/17/14, for [REDACTED] as needed (prn) for sleep. According to the March 2014 MAR, the resident received a prn dose of [REDACTED] on 13 nights. While staff monitored the resident's sleep, there was no indication of non-drug interventions attempted prior to the administration of the [REDACTED]. Additionally, there was no indication staff assessed that the resident frequently slept two to three, and sometimes as many as four or more hours on the day shift, which likely had an impact on her ability to sleep at night.</p> <p>Review of the resident's mood care plan identified the resident had a diagnosis of dementia and experienced, among other things, insomnia. Goals included the resident would sleep at least 5-6 hours at night. Interventions related to insomnia were identified as "1:1 support, calm environment and encourage good sleep hygiene. Encourage optimal sleep hygiene: quiet environment, limit caffeine after 4pm, lights off at bedtime, music, limit naps to 30 minutes during the day." There were no specific interventions staff should attempt prior to administration of the prn [REDACTED] identified.</p> <p>In an interview on 04/03/14 at 7:50 a.m., Staff C explained when staff entered the prn [REDACTED] order into the electronic MAR they failed to enter specific NDI and a place for staff to document what was attempted. She stated the facility's interdisciplinary team met on 02/17/14 and reviewed the resident's use of [REDACTED]. She stated that team should have identified the missing NDI, but failed to do so. She acknowledged NDI were not documented for this resident, and so staff were not able to determine what, if any, NDIs were used prior to the prn [REDACTED].</p>	F 329		

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F 329	Continued From page 31	F 329			
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED  Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to ensure meals were prepared and served according to the written, planned menu. Failure to ensure appropriate serving sizes, sodium restriction diets were honored and high protein high calorie supplements were served only to those residents who required them, placed residents at risk for high blood pressure, weight gain, and complications for residents on renal diets.  Findings include but are not limited to:  3rd FLOOR DINING Review of the menu for the lunch meal on 04/02/14 indicated residents should receive pork roast, cornbread dressing, squash medley, and sherbet for dessert. Observation revealed Staff K serve meals with two types of gravy on the pork depending on the type of diet that was ordered. According to Staff K, one gravy was for regular diets, the other had less salt and was intended for residents with 2 Gram sodium diets. Staff K was	F 363			

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*[Handwritten Signature]*

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F 363	<p>Continued From page 32</p> <p>noted to serve four ounces of gravy with pepper flakes to the sodium restricted diet and two ounces of white gravy to residents with regular diets.</p> <p>In an interview on 04/02/14 at 12:44 p.m., Staff E (Dietary Manager) indicated the gravy with the pepper flakes was for the regular diets and the white sauce was for the 2 gram sodium diets. Not only did residents on sodium restricted diets receive the wrong gravy, they received twice as much volume of the salted gravy. Failure to ensure residents received sodium restricted diets according to physician's orders and as directed by the menu placed resident at risk for medical complications.</p> <p>Staff K was observed to serve "Magic Cups" to residents for dessert rather than the sherbet as directed by the menu. Magic Cups are high protein (nine grams), high calorie (290 calories) ice cream supplements. In an interview on 04/02/14 at 12:24 p.m., Staff L (Registered Dietician) indicated these high calorie supplements should only be given as directed "... on the tray card or in the chart." Administration of high protein supplements had the potential to cause medical complications for residents with kidney problems.</p> <p>Additionally, review of the alternate menu indicated staff had scratched out "Hamburger steak", "French fries" and "Capri blend veg(etable)" and indicated that instead, "Tuna" and "Beet salad" should be served. In an interview on 04/02/14 at 1:22 p.m., Staff L stated, "We always have french fries, I don't know why we deviated from the menu." Staff L indicated, "We should go by original menu unless there is a</p>	F 363	<p><b>F 363</b></p> <p><b>3<sup>rd</sup> Floor Dining</b></p> <p>In an effort to promote consistent delivery of clinically ordered diets, the steam tables in the main kitchen and the satellite kitchenettes of 2<sup>nd</sup> and 3<sup>rd</sup> floors will be uniformly organized the same way for placement of sodium-restricted dietary items, and any other clinically ordered dietary items.</p> <p>Dietary staff will be inserviced regarding the importance of serving correct clinical diets in a consistent manner.</p> <p>The Dietary Services Manager will observe production tray lines and sample completed trays for accuracy in all three service locations.</p> <p>The Dietary staff will be inserviced regarding orders and use of supplement products served to residents, and the clinical goals for the use of each product.</p> <p>If residents receive a supplement product contraindicated for their medical diagnoses, staff will alert the licensed nurse of the situation to ensure resident is monitored for side effects.</p> <p>Supplements such as "Magic Cups", Health Shakes, Glucerna and Ensure will be stored in specifically labeled areas in the walk-in freezer and dry storage room to minimize the risk of procuring the</p>		

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F 363	<p>Continued From page 33</p> <p>good reason like we didn't have (the item). The original menu said hamburger and french fries, that's what it should be." While the menu items were changed, the serving sizes weren't altered to reflect the nutritional/ sodium/ portion sizes of the replacement menu items. Staff L confirmed that, "three ounces of hamburger steak and four ounces of french fries doesn't reflect the tuna sandwich, it (the food items) doesn't break out the same." Failure to ensure menus were accurate and followed placed residents at risk for unmet nutritional needs and dissatisfaction with their meals.</p> <p>Garlic bread was listed on the menu, however, residents who received a pureed diet were not offered or served garlic bread. On 04/02/14 at 12:55 p.m., Staff E stated "We don't puree the bread, because the residents don't like it, besides it (bread) gets too gummy."</p> <p>In and interview on 04/02/14 at 1:00 p.m., Staff L (RD), stated if an item was listed on the menu then it should be offered to all residents including those on pureed diets.</p> <p><b>RESIDENT #93</b> Resident #93's meal card revealed she was to receive small portions, however staff were observed to use a green scoop, which was for regular serving sizes. According to Staff E, staff should have used a blue scoop (small serving) for residents ordered to receive small portions.</p> <p><b>2nd FLOOR DINING</b> Observation of the lunch meal on 04/02/14 in the 2nd floor dining room revealed the following: Staff P, Dietary Aide, offered Resident #268 ice cream. She explained she couldn't have dairy and</p>	F 363	<p>incorrect product for residents with restricted diets.</p> <p>The Dietary staff will make every effort to follow menus as written. The clinical diet spreadsheets will be in agreement with the planned menus that are made public to the residents.</p> <p>The Dietary staff will be inserviced on appropriate substitutions that are equivalent in nutritional value to ensure resident nutrition needs are met. The Dietary Services Manager will monitor daily production to observe compliance with menus as written. The Dietitian will ensure the nutritional content of the menus meets individual resident needs.</p> <p>Residents requiring altered consistency diets will receive all items on the menu as written, with adjustment provided for likes and dislikes of individual residents. The Dietary staff have the ability to provide any ordered texture and will ensure all menu items are delivered.</p> <p><b>RESIDENT #93</b> Resident #93 is not on a restricted diet. Small portions were by request of the resident and not clinically required. She experienced no negative effects of receiving a regular size portion of menu items.</p> <p>All residents are at risk of potential adverse side effects if nutritional portion control is not followed as prescribed.</p>		

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F 363	<p>Continued From page 34</p> <p>refused the offer. Dairy was noted to be identified as a dislike on her tray card. Resident #256's tray card identified he was to receive a No Concentrated Sweets (NCS) diet. He was observed to consume a Magic Cup and a serving of vanilla wafers. Resident #260 was observed to consume a Magic Cup.</p> <p>Staff P explained that while the menu identified sherbet as the dessert, there was only a limited amount available, so he offered residents all the flavors of ice cream, including the Wild Berry Magic Cup. Staff P was unaware that the Magic was high calorie and high protein and might not be appropriate for all residents.</p> <p>In an interview at 12:50 p.m. Staff P stated NCS diets should not have ice cream and he usually served those residents fruit. He explained that while the menu specified vanilla wafers as the dessert for residents on a NCS diet, they were on the menu yesterday as well so he offered something different. He also explained some residents on a NCS wanted the regular dessert and so he honored that choice. He stated he did not notify nursing staff when a resident chose a regular dessert so they could be assessed and monitored for any side effects.</p> <p>At 12:55 p.m., Staff P explained to Resident #127 he was out of sherbet and offered her Wild Berry, chocolate or strawberry ice cream. At 1:00 p.m. a CNA ordered a room tray for Resident #272. His written menu identified a request of sherbet. Staff P provided strawberry ice cream. Resident #7's tray card identified she was to receive a NCS diet with small portions. She was served regular portions of all menu items and strawberry ice cream.</p>	F 363	<p>Facility staff will provide food portions in compliance with orders.</p> <p>Dietary staff responsible for serving food from menu spreadsheets will be inserviced to ensure knowledge of appropriate scoops to be used for each menu item.</p> <p>The Dietary Services Manager will monitor performance of each serving associate to ensure competency, and will ensure compliance.</p> <p><b>2<sup>nd</sup> Floor Dining</b></p> <p>Dietary aides responsible for procuring food from the kitchen, delivering to satellite kitchens and preparing resident room trays and dining room trays will be inserviced regarding food serving procedures. Compliance will be emphasized in:</p> <ul style="list-style-type: none"> <li>• Following resident likes and dislikes listed on dietary tray cards.</li> <li>• Following the menu as written, and not deviating without consulting with Food Service Supervisor or Dietitian and/or Nurse.</li> <li>• Proper use and serving of ordered dietary supplements.</li> <li>• Serving portion sizes as ordered or requested.</li> </ul>	
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F 363	Continued From page 35  In an interview on 04/02/14 at 2:25 p.m. Staff E stated the main kitchen had more sherbet that could be delivered to the kitchenettes when they ran out had Staff P requested it. He also explained the Magic Cups were a new addition to the kitchen and he had not developed a policy or directed his staff on who should or should not receive it. He acknowledged menus and tray cards should be followed.	F 363	<ul style="list-style-type: none"> <li>Obtaining assistance from licensed nurses when residents desire menu items that are contraindicated for their medical diagnoses. Resident education will be provided by nurses regarding risks and benefits of choosing food items outside the parameters of recommended clinical diets.</li> </ul>	5/20/14
F 492 SS=D	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD  The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.  This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to continue to provide items and services as requested by two (#s 153 & 146) of two resident and/resident representatives who requested demand bills, pending the results of the demand bill. Failure to provide the services as requested violated the residents' claim appeal rights.  Findings include:  According to guidelines, if a Skilled Nursing Facility provider believes on admission or during a resident's stay that Medicare will not pay for	F 492		

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F 492	<p>Continued From page 36</p> <p>skilled nursing or specialized rehabilitative services and that an otherwise covered item or service may be denied as not reasonable and necessary, the facility must notify the resident or his/her legal representative in writing. This notice requirement may be fulfilled by use of the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) (CMS form 10055). The SNFABN and the Denial Letters inform the beneficiary of his/her right to have a claim submitted to Medicare and advises them of the standard claim appeal rights that apply if the claim is denied by Medicare. These claims are often referred to as "demand bills" and are reviewed by the Fiscal Intermediary (FI) or Medicare Administrative Contact (MAC).</p> <p>The facility provided a list of Medicare beneficiaries who requested demand bills in the past six months, Resident #s 153 and 146 .</p> <p><b>RESIDENT #153</b> The SNFABN, dated 11/29/13, instructed Resident #153 "You need to make a choice about receiving these health care items or services... It is not Medicare's opinion, but our opinion, that Medicare will not pay for the items or services described below... The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it." The facility indicated "Skilled therapys are ready to discharge from therapy services due to resident is at her highest level of functional ability." "The purpose of this form is to help you make an informed choice about whether nor not you want to receive these items or services, knowing that you might have to pay for them yourself...". The resident/ resident representative chose "Yes. I want to receive these items or services."</p>	F 492	<p><b>F 492</b></p> <p>The facility will ensure that it does not violate Medicare claim appeal rights of residents. Should future residents who are on skilled nursing and or therapy services request a Demand Bill, the facility will educate them regarding the process and the potential costs they would incur should their appeal be denied. During the process, all therapy and skilled nursing services being provided will continue until a final determination has been made on the appeal.</p> <p>The Administrator will ensure compliance.</p>	5/20/14

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F 492	<p>Continued From page 37</p> <p>In an interview on 04/01/14 at 12:51 p.m. Staff Q reviewed the rehabilitation records and indicated Occupational Therapy (OT) and Physical Therapy (PT) discontinued on 11/20/13, and Speech Language Therapy (SLP) on 11/29/13. Staff Q said the resident was not making any progress and was discontinued from Skilled Therapy caseload and referred to a restorative program.</p> <p>In an interview on 03/31/14 at 1:08 p.m. Staff R, Case Manager, said therapy was discontinued, with the last covered day of 12/01/13. Staff R was aware the resident's representative wanted to continue skilled therapy and the facility did not continue services.</p> <p>RESIDENT #146 Similar findings were noted for Resident #146 whose 02/11/14 SNFABN indicated the resident wanted to continue skilled therapy services pending the results of a demand bill. The facility failed to provide those services from 02/14 through 03/13/14.</p> <p>In an interview on 04/01/14 at 1:02 p.m. Staff A indicated the above residents should have remained on therapy services and were not given the opportunity to dispute/appeal the facility's decision to end their Medicare benefit.</p>	F 492		
F 514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete;</p>	F 514		

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F 514	<p>Continued From page 38</p> <p>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 interview and record review it was determined that the facility failed to ensure clinical records were maintained on each resident that were complete and accurate. The facility failed to ensure a system by which injection sites and bowel movements were accurately recorded; that oxygen saturation rates and oxygen use were clear; that consults were located in the resident's record and that forms were located in the correct resident's record. Failure to ensure clinical records were accurate and complete prevented staff from ensuring resident's needs were met.</p> <p>Findings include but are not limited to: Refer to : CFR 483.25, F309, Provide Care/Services</p> <p><b>INJECTION SITE</b> <b>RESIDENT #146</b> Review of Resident#146's record revealed she received Heparin injections, subcutaneously, three times a day. Review of the Medication Administration Record revealed staff recorded the administration site of each injection. While staff had the ability to, and frequently did, record the location of administration as "abdomen" with the</p>	F 514	<p><b>F 514</b></p> <p><b>INJECTION SITE</b> Residents receiving injections will have the injection sites accurately documented to assure the prevention of adverse effects of receiving multiple injections in one area.</p> <p>Licensed nursing staff will be inserviced regarding accurate documentation of injection sites for nurses on following shifts to reference.</p> <p>Sample audits of the E-MARs for residents receiving injections will be performed for 90 days with audit findings reported to the QAPI Committee monthly to make sure the solution is sustained.</p> <p><b>OXYGEN USE</b> The facility has modified the method of entering O2 administration and O2 saturation monitoring in the computer to ensure more accurate documentation. Licensed nurses and Medical Records staff will be inserviced to the changes.</p> <p>Sample audits of the E-MARs for residents using oxygen will be performed for 90 days with audit findings reported to the QAPI Committee monthly to make sure the solution is sustained.</p>	

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F 514	<p>Continued From page 39</p> <p>specific placement on the abdomen, at other times staff simply recorded "abdomen". For example, on 03/03, 04, 08, 13, 14, 16, 18, 22, 24 and 28/14 staff recorded the injection site as "abdomen". This prevented the next staff who administered an injection from knowing where on the abdomen the injection occurred in order to rotate the site.</p> <p>Similar findings were identified for Resident #s 36, 111, 118 and 271 for whom staff failed to consistently document the specific site to which an injection was administered.</p> <p><b>OXYGEN USE</b> A physician's order, dated 03/18/14, directed staff to administer Oxygen at 2 liters per minute at night. Review of the March MAR revealed staff documented the resident's oxygen saturation rate every shift. However, based on the documentation, it was not always clear whether the resident was using the oxygen when the saturation rate was obtained or not. For example, on On 03/24, 26, 29, 30 and 31 staff documented the oxygen saturation rate, but did not record the amount of oxygen used. Failure to clearly document the use of oxygen placed the resident at risk to not be accurately monitored and assessed.</p> <p><b>BOWELS</b> Review of Bowel Monitor (BM) Records for Resident #191 revealed discrepancies between Nurses Aide and Medication Administration Record documentation regarding BMs. Failure to ensure accurate BM documentation detracted from staff's ability to administer bowel medications as required.</p>	F 514	<p><b>BOWELS</b></p> <p>All residents will have documentation of bowel activity by nursing assistants and licensed nurses that enables accurate assessment and treatment as required.</p> <p>Licensed nurses will receive inservice training regarding the importance of accurate recording of bowel movements in the computer that reflects data submitted by nursing assistants.</p> <p><b>RECORDS</b> The Tray Monitor Record for Resident #123 has been removed from the closed record of Resident #118 and placed in the appropriate record location.</p> <p>The Podiatry consults for Resident #21 have been obtained and filed appropriately in the medical record for Resident #21.</p> <p>Medical Records staff will be inserviced regarding accurate filing of medical record information in the appropriate resident chart. The Medical Records Supervisor will audit all charts of residents receiving podiatric services to ensure that all consults are in place in the appropriate medical records.</p> <p>The Director of Nursing and Medical Records Supervisor will ensure compliance.</p>	5/20/14
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*[Handwritten Signature]*

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

PRINTED: 04/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505513</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/03/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>STAFFORD HEALTHCARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2800 SOUTH 224TH STREET, DES MOINES, WA 98198</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 40 <b>RECORDS</b> The February 2014 Tray Monitor Record for Resident #123's was located in #118 closed record.  Record review revealed Podiatry consults dated 12/07/13 and 02/27/13 were not readily available in Resident #21's record. On 04/03/14, Staff G contacted Podiatry services and had these documents faxed to the facility.	F 514		

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