

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

PRINTED: 09/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505327	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/10/2014
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NAME OF PROVIDER OR SUPPLIER AVAMERE OLYMPIC REHABILITATION OF SEQUIM	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 5TH AVENUE SOUTH SEQUIM, WA 98382
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Off-Hours Quality Indicator Survey conducted at Avamere Olympic Rehabilitation of Sequim on 09/07/14, 09/08/14, 09/09/14 and 09/10/14. The survey included data collection on 09/07/14 from 7:00 p.m. to 9:15 p.m. A sample of 39 residents were selected from a census of 80. The sample included 30 current residents and the records of 9 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>Sonya Conway, MSW Erika Hurley, MS Jonathan Berliner, RN, MN, CPG Rebecca Kane, RN, MN</p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging and Long Term Support Administration Residential Care Services, District 3, Unit D P.O. Box 45819 Olympia, Washington 98504-5819</p> <p>Telephone: 360.664.8420 Fax: 360.664.8451</p> <p><i>Robm Bullnell</i> 9/18/14 Residential Care Services Date</p>	F 000	<p>The filing of this plan of correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This plan of correction is filed as evidence of the facility's effort to comply with the requirements of Medicare and Medicaid participation and to continue to provide a high quality of resident care.</p> <p style="text-align: center;">RECEIVED OCT 07 2014 DSHS/ADSA/RCS</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Heather Jetter</i>	TITLE Administrative	(X6) DATE 10/3/14
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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 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure a plan of care for skin impairment was completed for 1 of 27 sampled residents (#22) reviewed for care and services. This failure placed residents at risk of receiving inadequate care and services to meet individual need.</p> <p>Findings include:</p> <p>On [REDACTED] Resident #22 was admitted to the facility with diagnoses including anemia, dementia and depression.</p>	F 279	<p>F279</p> <ol style="list-style-type: none"> 1. Resident #22 from closed record sample discharged facility on [REDACTED] 2. Other residents at risk for potential and/or actual skin impairments have been identified and their plan of care reviewed and updated as indicated. Licensed nurse have been educated on initiating (actual/at risk) skin impairment care plans. 3. Resident's care plans will be reviewed and updated as indicated by Licensed Nurse evaluation upon admit, quarterly, annually, and with significant change of condition. 4. Care plans will be initiated upon admit and audited quarterly with the MDS process and as needed. Audit data will be tracked and reviewed monthly until compliance maintained for 3 months, then quarterly during the Quality Assurance Process Improvement (QAPI) meeting. Policy and Procedure will be reviewed and updated as indicated through QAPI process. 5. Date of compliance: 10/15/14 6. The Administrator and/or Director of Nursing (DNS) is responsible for policy and procedure revision and compliance. Staff Development is responsible for staff education. 		

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F 279	Continued From page 2 The 14-Day Minimum Data Set (MDS), an assessment tool, dated [REDACTED] indicated the resident had some cognitive impairment and required extensive one person assistance with activities of daily living including bed mobility, transfers and toileting. The MDS documented the resident was at risk for pressure ulcers and had no unhealed pressure ulcers. On 5/25/14 at 1:26 p.m., a progress note documented a new open area to the coccyx. The resident reported increased tenderness at the open site. Record review noted during the 5/29/14 care conference meeting, Resident #22's daughter stated the resident had a pressure sore. Nursing staff indicated they were aware and cream had been ordered. The resident's care plan for risk or actual skin impairment was initiated on 6/8/14. The care plan goal documented a new skin event initiated on 6/4/14 for a "small stage II on coccyx." Review of the care plan determined there was not a risk or actual skin impairment plan included prior to 6/4/14. On 9/10/14 at 3:56 p.m., Licensed Nurse (LN) A stated there was not care plan for skin impairment prior to the 6/4/14 new skin event. LN A stated, "On admit every resident should have a skin impairment care plan."	F 279		
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		

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F 309 SS=D	<p>Continued From page 3 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> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to consistently implement monitoring and treatment of constipation for 1 of 5 current sampled residents (#11) reviewed for unnecessary medications. This failure placed residents at risk for fecal impaction, discomfort and delayed medical treatment.</p> <p>Findings include: The facility's Bowel Care Protocol documented, "It is the policy of this facility to monitor the bowel records of residents to assure they attain a normal bowel pattern for them without complications. 1. If a resident has not had a bowel movement (BM) for three consecutive days...please observe the following protocol after a physician order has been obtained: A. Evening shift is to run the look back report for residents who have not had a bowel movement for two consecutive days. B. Evening shift is to give the milk of magnesia (MOM). If no results, then C. Day shift is to give the suppository. If no results, then D. Fleets' enema will be given. If no results, complete a focused assessment...and notify the Doctor..."</p>	F 309	<p>F309</p> <ol style="list-style-type: none"> Resident #11 has been evaluated by the Licensed Nurse and Physician. Medications have been provided as ordered and care plan has been updated as indicated. Other residents at risk for irregular bowel movements were identified. Medications and interventions have been provided as indicated. Bowel movement Policy and Procedure has been reviewed. NAC staff were educated on documenting resident bowel movements. LN staff were educated on monitoring resident's bowel movements. The Licensed Nurse will monitor for no bowel movement within time frame per policy and provide medications as indicated. The RCM or designee will monitor resident bowel records daily. The DNS and/or designee will audit resident bowel records weekly. Audit data will be tracked and reviewed monthly until compliance maintained for 3 months, then quarterly during the Quality Assurance Process Improvement (QAPI) meeting. Policy and Procedure will be reviewed and updated as indicated through QAPI process. Date of compliance: 10/15/14 The Administrator and/or Director of Nursing (DNS) is responsible for policy and procedure revision and compliance. Staff Development is responsible for staff education. 	
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F 309	<p>Continued From page 4</p> <p>Resident #11 was readmitted to the facility on [REDACTED] and on [REDACTED] with diagnoses including respiratory failure, Alzheimer's disease, pain, constipation, renal failure, cancer, heart failure, depression, psychosis, anxiety, and iron deficiency.</p> <p>The resident's Minimum Data Set, dated 06/11/14, indicated the resident had moderate cognitive impairment, required extensive assistance with activities of daily living including toilet use, and received pain and psychotropic medications.</p> <p>The resident's care plan, last reviewed on 06/12/14, showed the resident required assistance of one (1) person for toileting, received pain medications due to acute/chronic pain, and received psychotropic medication due to alteration in cognition. The care plan noted, "Antidepressant Side Effects: constipation..."</p> <p>The Physician Orders included the following, ordered on 06/09/14, for Bowel Care: MOM 30ml (milliliters) po (by mouth) PRN (as needed) for constipation if no BM for 6 shifts Bisacodyl suppository q8hrs (every 8 hours) PRN for constipation if no BM after MOM Fleet Enema PRN for constipation if no BM by 3rd day.</p> <p>The Physician Orders included the following medication orders: Ordered on 06/10/14-Ferrous Sulfate (iron) 325mg (milligrams) po qd (one time daily) for iron deficiency Ordered on 06/09/14 [REDACTED] (antidepressant) 15mg po qd for depression</p>	F 309		

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F 309	<p>Continued From page 5</p> <p>Ordered on 06/09/14- [REDACTED] (antianxiety) 0.5mg po q8hrs for psychosis</p> <p>Ordered on 06/10/14- [REDACTED] (pain medication) 5mg po q4hrs PRN for pain</p> <p>The Lippincott Williams & Wilkins Nursing 2014 Drug Handbook, documented the following medications have an adverse reaction of constipation: Ferroul Sulfate, Mirtazapine, Clonazepam and Roxicodone.</p> <p>Record review of the BM record showed Resident #11 had two (2) episodes of not having a BM for more than 9 shifts (3 days) on 07/09/14 NOC (nocturnal shift) to 07/13/14 NOC-10 shifts and on 07/30/14 NOC to 08/02/14 NOC-10 shifts.</p> <p>Record review of the July 2014 and August 2014 Medication Administration Record (MAR) showed the Bowel Protocol, or other constipation interventions were not administered from 07/09/14 to 07/13/14 and from 07/30/14 to 08/02/14, periods of more than 9 shifts without a BM.</p> <p>On 09/10/14 at 2:41 p.m., Licensed Nurse (LN) E stated when residents have six (6) shifts without a BM, they are offered MOM. If the MOM is not effective, a suppository is given the next shift. And if the suppository is not effective, an enema is given. If the resident tends to need the bowel protocol, the nurse will follow up with the doctor. The facility tries to be proactive.</p> <p>LN E indicated the documentation in the Bowel Record and MAR showed Resident #11 had two (2) periods of time of 10 shifts without a BM and without the bowel protocol, or constipation interventions, being administered.</p>	F 309			

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F 309	Continued From page 6 At 3:15 p.m., Resident #11 stated prior to going to the hospital (on [REDACTED]) she had problems having regular bowel movements. At 3:36 p.m., the Director of Nursing Services stated the facility expects the nurses to following the bowel protocol.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to provide facial hair grooming for 1 of 19 current sampled residents (#150) reviewed for activities of daily living (ADL). This failure placed residents at risk of inadequate grooming and diminished quality of life. Findings include: Resident #150 was readmitted to the facility on [REDACTED] with diagnoses including Alzheimer's disease, depression and non-Alzheimer's dementia. The resident's 14-Day Minimum Data Set, an assessment tool, dated [REDACTED] indicated the	F 312 F 312	1. Resident #150 was assessed and facial hair removed per resident preference and care plan updated accordingly. Resident #150 discharged on [REDACTED] 2. Other residents at risk for chin hair have been assessed for preference and care plans have been updated with his/her preferences. 3. Staff have been educated on assessing resident preferences related to facial hair and removing as indicated according to resident preference. Licensed Nurses have been educated on updated NAC tasks with hair removal preference. 4. Facial hair is monitored during Caring Partner rounds and during routine daily care and addressed as indicated per resident preference. Caring Partner audit data will be tracked and reviewed monthly until compliance maintained for 3 months, then quarterly during the Quality Assurance Process Improvement (QAPI) meeting. Policy and Procedure will be reviewed and updated as indicated through QAPI process. 5. Date of compliance: 10/15/14. 6. The Administrator is responsible for policy revision. The DNS and/or designee is responsible for compliance. Staff Development nurse is responsible for staff education.	

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F 312	<p>Continued From page 7</p> <p>resident was severely cognitively impaired and required 1-2 person physical assistance with ADL care.</p> <p>The CNA/NAC Standard of Care documented daily morning care was to include: wash hands and face, peri-care post incontinence, dress in day clothes, comb and brush hair, shave as needed, make-up, oral care, shower per schedule and vital signs as assigned.</p> <p>On 9/8/14 at 2:46 p.m., the resident was observed with white chin hairs.</p> <p>On 9/10/14 at 1:20 p.m., Resident #150 was seated in her wheelchair in the hallway. White chin hairs, ¼ - ½ inch long, were visible.</p> <p>Review of the care plan for ADL care, initiated on 6/24/14, did not address personal hygiene or facial grooming.</p> <p>On 9/10/14 at 1:24 p.m., Licensed Nurse (LN) A stated morning care is performed by the nursing aides (NA). The NA will assess the resident's needs and offer morning care tasks as assigned in the standards of care. Shaving is done depending on the resident's preference and done on an as needed basis. For men it may be completed with showers and for women, offered every morning as needed.</p> <p>When asked about Resident #150's care plan regarding personal hygiene and facial hair shaving, LN A stated, "I'm not sure if I have entered that...It would normally be under ADLs and looks like it's not."</p> <p>At 1:53 p.m., LN A stated she had the NA take the</p>	F 312		

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F 312	Continued From page 8 resident to her room for a shave. LNA stated, "I asked the aide if she had noticed her [resident] chin hair this morning and she stated she missed that."	F 312	F314 1. Resident #22 from closed record sample discharged facility on [REDACTED]	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable, and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide services to prevent and heal pressure ulcers for 1 of 7 sampled residents (#22) reviewed for pressure ulcers. This failure placed residents at risk of avoidable and untreated pressure ulcers. Findings include: On [REDACTED] Resident #22 was admitted to the facility with diagnoses including anemia, dementia and depression. The 14-Day Minimum Data Set (MDS), an assessment tool, dated [REDACTED], indicated the resident had some cognitive impairment and required extensive one person assistance with	F 314	2. Other residents at risk for potential and/or actual skin impairments have been identified and their plan of care reviewed and updated as indicated. Needed interventions have been identified and initiated as indicated. Licensed nurses have been educated on skin evaluation/assessment, documentation of skin evaluation/assessment, reporting of alteration in skin, and interventions to be implemented for risk or actual alterations in skin. Residents will have skin evaluation upon admit, weekly, and as indicated with change in condition. Resident's care plans have been updated as indicated and skin alterations reported to the RCM. Residents with skin alterations are on alert. 3. The Resident Care Manager (RCM) and DNS review alerts during daily IDT meeting. Resident's plans of care are reviewed and updated as indicated by Licensed Nurse evaluation upon admit quarterly, annually, and with significant change of condition. 4. The DNS and/or designee will audit skin documentation and care plans upon admit and quarterly, with the MDS process. Audit data will be tracked and reviewed monthly until compliance maintained for 3 months, then quarterly during the Quality Assurance Process Improvement (QAPI) meeting. Policy and Procedure will be reviewed and updated as indicated through QAPI process. 5. Date of compliance: 10/15/14 6. The Administrator and/or Director of Nursing (DNS) is responsible for policy and procedure revision and compliance. Staff Development nurse is responsible for staff education.	

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F 314	<p>Continued From page 9</p> <p>most activities of daily living including bed mobility, transfers and toileting. The MDS documented the resident was at risk for pressure ulcers and had no unhealed pressure ulcers. No ulcers were documented as present on the prior assessment.</p> <p>A progress note, dated 5/22/14, documented the resident reported mild pain to the coccyx and back.</p> <p>On 5/25/14 at 1:26 p.m., a progress note documented a new open area to the coccyx. The resident reported increased tenderness at the open site.</p> <p>At 10:01 p.m., a progress note documented the resident had a closed Stage I pressure ulcer to the sacrum.</p> <p>Record review noted during the 5/29/14 care conference meeting, Resident #22's daughter stated the resident had a pressure sore. Nursing staff indicated they were aware and cream had been ordered.</p> <p>On 5/29/14, a progress note documented, "no open areas" on the resident's coccyx.</p> <p>Progress notes, dated 5/31/14, 6/1/14, 6/2/14 and 6/5/14, documented an open area at the top of "intergluteal cleft."</p> <p>On 6/1/14, the Utilization Review documented the resident had a small blanchable red area on the coccyx.</p> <p>On 6/5/14, a progress note indicated an open wound on the coccyx. The doctor was notified</p>	F 314		
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F 314	<p>Continued From page 10 and orders requested.</p> <p>The weekly wound progress note, dated 6/6/14, documented a 0.4 centimeter (cm) x 0.4 cm Stage II pressure ulcer to the coccyx.</p> <p>The 6/11/14, the Utilization Review documented the resident had a Stage II open area to the coccyx.</p> <p>The resident's care plan for risk or actual skin impairment was initiated on 6/8/14. The care plan goal documented a new skin event initiated on 6/4/14 for a "small stage II on coccyx."</p> <p>Review of the care plan documented there was not a risk or actual skin impairment plan included prior to 6/4/14.</p> <p>On 9/10/14 at 3:56 p.m., Licensed Nurse (LN) A stated skin assessments are completed once a week by LNs. If the LN notices a new skin issue, a progress note should be completed, an accident/incident report completed, and the family and doctor should be notified.</p> <p>LN A stated she did not see an accident/incident report for Resident #22's pressure ulcer and no care plan for skin impairment was completed prior to the 6/4/14 new skin event.</p> <p>LN A stated, "On admit every resident should have a skin impairment care plan."</p> <p>After the open area was identified and documented, further interventions and treatments were not initiated for wound healing.</p>	F 314			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505327	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/10/2014
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NAME OF PROVIDER OR SUPPLIER AVAMERE OLYMPIC REHABILITATION OF SEQUIM	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 5TH AVENUE SOUTH SEQUIM, WA 98382
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<p>F 333 F 333 SS=D</p>	<p>Continued From page 11 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide an ordered medication for 1 of 16 current sampled residents (#161) reviewed for unnecessary medications and medication administration. Failure to ensure the resident received his ordered diuretic (a medication to decrease swelling) placed the resident at risk for health complications and discomfort.</p> <p>Findings include:</p> <p>Resident #161 was admitted to the facility on [REDACTED] after having surgery, with diagnoses including pneumonia, high blood pressure, and breathing difficulties caused by chronic obstructive pulmonary disease.</p> <p>Resident #161's admission orders included: furosemide (a diuretic) 20 milligrams (mg) by mouth daily as needed for weight gain.</p> <p>According to facility documentation, staff clarified the admission order on 9/4/14 at 11:00 p.m. with an on-call physician who ordered "lasix (furosemide) 20 mg if weight > (greater than) 170 lb."</p> <p>The following weights, between 9/4/14 and 9/9/14, were above the 170 pound (lb) weight limit</p>	<p>F 333 F 333</p>	<p>F333</p> <ol style="list-style-type: none"> 1. Resident #161 was evaluated and assessed. The resident and the resident's physician were notified of the missed medication. The resident was placed on alert charting observation and closely monitored. 2. The medication transcription procedure was revised to protect residents from like occurrences. Licensed Nurses were educated on medication transcription process. 3. The RCM and/or DNS will audit transcription of medication orders during IDT meeting. 4. Results of transcription audit will be tracked and reviewed monthly until compliance maintained for 3 months, then quarterly during the Quality Assurance Process Improvement (QAPI) meeting. Policy and Procedure will be reviewed and updated as indicated through QAPI process. 5. Date of compliance: 10/15/14 6. The Administrator is responsible for policy revision and the DNS is responsible for compliance. Staff Development is responsible for staff education. 	
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F 333	<p>Continued From page 12 set by the doctor on 9/4/14: 9/4/14-174 lb 9/5/14-175 lb 9/6/14-179 lb 9/7/14-175 lb 9/8/14-no weight listed 9/9/14-177 lb</p> <p>The resident's Medication Administration Record (MAR) showed the resident received furosemide 20 mg on 9/6/14 at 7:49 a.m. and on 9/9/14 at 7:08 a.m. There was no documentation on the MAR showing the resident received the indicated furosemide dose on 9/5/14, 9/7/14, or 9/8/14.</p> <p>On 9/9/14 at 2:05 p.m., Licensed Nurse (LN) A indicated the dose of furosemide was not given on 9/5/14 indicating there was remaining confusion about when the medication should be given and how often.</p> <p>Record review showed on 9/5/14 a response fax communication was received from the physician to change the furosemide order from "as needed" to "every day."</p> <p>On 9/9/14 a fax communication from LN B to the physician stated, "Order (for furosemide every day) was not updated in MAR and Lasix (furosemide) not administered since 9/6/14 at 0800." The fax indicated the resident had wheezing in his lungs, significant swelling to his right leg/foot, and fluid weeping from his leg/foot when pressure was applied.</p> <p>On 9/9/14 at 4:32 p.m., the resident stated his legs were more swollen the past few days and caused him some pain, especially if they were pressed on.</p>	F 333		

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F 333	Continued From page 13 The resident was observed to be sitting in a wheelchair with his feet resting on the floor. The resident had compression stockings in place to both legs with noticeable swelling to both feet. On 9/10/14 at 2:54 p.m., the Director of Nursing Services stated a medication error occurred when the resident did not receive his furosemide on 9/08/14. On 9/10/14 at 4:30 p.m., LN C indicated she had given the furosemide on 9/7/14 and documented it on the MAR. LN C stated a computer error must have occurred when LN D transcribed the order from "as needed" to "every day."	F 333			