

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

PRINTED: 03/18/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505154 1377	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2013
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NAME OF PROVIDER OR SUPPLIER TACOMA NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2102 SOUTH 96TH STREET TACOMA, WA 98444
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Tacoma Nursing And Rehabilitation Center on 2/21/13, 2/22/13, 2/25/13, 2/26/13, 2/27/13, 2/28/13, 3/01/13, 3/4/13 and 3/5/13. A sample of 39 residents was selected from a census of 95. The sample included 34 current residents and the records of 5 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>██████████s, RN, BSN, MN ██████████ RN, BSN, MBA ██████████ RN, MSN</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, Region 5, Unit B 1949 South State Street MS: N27-24 Tacoma, Washington 98405-2850</p> <p>Telephone: 253-983-3800 Fax: 253-589-7240</p> <p><i>[Signature]</i> Residential Care Services</p>	F 000	<p>RECEIVED</p> <p>MAR 29 REC'D</p> <p>DSHS - ADSA RCS - REGION 5</p>	4/8/13
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 3/29/13
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to ensure timely</p>	F 157	<p>F000 Initial Comments</p> <p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Tacoma Nursing and Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>F157</p> <p>The physician for resident #109 was notified of the [REDACTED] on resident's thigh and the open area on resident's [REDACTED] on 2/28/13.</p> <p>Residents on alert have the potential to be affected. Residents on alert were reviewed by RCM's to ensure</p>	4/8/13	

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F 157	<p>Continued From page 2</p> <p>notification to the physician for change in condition for 1 of 3 Sampled Residents (#109) reviewed when staff discovered the resident sustained a [redacted] and developed an open area to the [redacted]. This failure resulted in delayed notification and treatment initiated without an actual telephone order.</p> <p>Findings include:</p> <p>Refer to F-309</p> <p>Resident #109 was admitted to the facility in 2011 with multiple medically disabling conditions. A Minimum Data Set (MDS), an assessment tool, dated 1/15/13, documented the resident required extensive assistance with activities of daily living including transfers into and out of her electric wheelchair.</p> <p>Record review of a chart note dated 2/26/13 at 8:45 p.m., found Staff J documented Resident #109 had a [redacted] to her upper left thigh that measured 5 cm (centimeters) by 4.6 cm that was "reddish." The note documented the resident said she had spilled coffee on her leg. The note also documented Staff N found a 0.4 x 0.2 cm open area to her [redacted]. Staff N cleansed the area and applied a "hydrogel" dressing to the area and covered the area with "foam." The note indicated Staff N had notified the physician and obtained orders for the hydrogel.</p> <p>Record review of a physician order dated 2/28/13 at 8:30 a.m., documented the physician was called and gave the facility an order for the Hydrogel to be placed on the [redacted] area opening on 2/28/13.</p>	F 157	<p>physician was notified of all issues as well as documentation of any new orders.</p> <p>Licensed nurses were re-educated by the DNS regarding timely physician notification of resident changes in order to avoid a delay in treatment.</p> <p>Nursing progress notes will be reviewed daily to ensure timely physician notification and initiation of orders, this will occur as part of the daily MACC review (Monitoring Acute Condition Change). DNS will document any issues during this review.</p> <p>A copy of audits with findings will be provided to the DNS for review and follow up as necessary. Issue will be reviewed at monthly Performance Improvement Meeting for three months or until resolved to ensure continued compliance.</p>	4/8/13	

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F 157	Continued From page 3 A chart note dated 2/28/13, documented the call to the physician regarding the [REDACTED] wound was not initiated until 2/28/13. On 3/4/13, Staff E reported Staff B notified the the physician on 3/1/13, and could not verify the physician received notification of the [REDACTED] or the wound on 2/26/13 by voicemail. The physician was not notified in person of the resident's condition until 2/28/13 when the wound treatments were clarified. On 3/7/13 in a telephone interview, Staff E said staff was able to provide first aid treatments without a direct order from the physician but treatment orders (such as wound care) should be obtained before treatments are started. The facility failed to provide Resident #109's physician with timely notification regarding a change in her condition when she sustained a burn on her leg and developed an open area to her [REDACTED].	F 157		4/8/13	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would	F 225	F225 Investigations for resident's #40 and #109 have been initiated and completed. Residents with current investigations have the potential to be affected.		

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F 225	<p>Continued From page 4</p> <p>indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</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 immediately thoroughly investigate and protect 2 of 3 Sampled Residents (#'s 40 & 109) regarding possible allegations of abuse and neglect. These failures had the potential to place these resident at risk for further potential abuse and neglect or self injury.</p>	F 225	<p>The Investigation Nurse re-educated the DNS and LN's on the need to immediately initiate an investigation for all allegations.</p> <p>Incidents will be reviewed daily during morning stand up meeting to assure investigations were initiated in a timely manner.</p> <p>Care Partner program will be initiated to identify potential allegations to assure timely follow up/investigations has been initiated on resident concerns as needed.</p> <p>Care Partner sheets will be reviewed by Administrator weekly for four weeks, then monthly for three months. Findings will be reviewed at the Performance Improvement Meeting for three months or until resolved to ensure continued compliance.</p>	4/8/13

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F 225	Continued From page 5 Findings include: Record review of the facility "Abuse Prevention Program" found it was policy for the facility to provide a safe environment for residents. The policy documented, "In the event of an occurrence the Occurrence Report will be used to document the event and...will be completed at the time of the event and the initial investigation will begin at that time." Investigation was to begin immediately upon identification or report of abuse or neglect for the protection of residents. RESIDENT #40 Resident #40 was admitted to the facility in 2010 with multiple medically disabling diagnoses to include difficulty in walking, muscle [REDACTED], [REDACTED] and [REDACTED]. A Minimum Data Set (MDS), an assessment tool, dated 12/30/12 documented the resident required limited to extensive for various activities of daily living. He could participate with bathing if staff assisted him with set up. According to Nursing Care Directives dated 2012, Resident #40 required staff to assist him with some hygiene tasks. On 2/22/13 at 8:37 a.m., Resident #40 was observed in his room while seated in his electric wheelchair. Resident #40 was alert, oriented and able to interview. Resident #40 stated he had an incident with Staff J the "other day." Resident #40 said he had called out for Staff J to remove his dinner tray from his room and Staff J "got on me"	F 225		4/8/13	

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F 225	Continued From page 6 for calling out rather than using the call light.	F 225		4/8/13
	<p>Resident #40 also stated Staff J had thrown a towel at him rather than hand it to him when the resident requested hygiene assistance. Resident #40 said he wrote a note to a manager (Staff B) "Two days ago" but had not heard back from her. Resident #40 said Staff B was very busy. Resident #40 said Staff J was "pretty much rude to me that day."</p> <p>At 3:34 p.m., Staff B said she had received a note from Resident #40 on 2/20/13. The note was reviewed by Staff B and two surveyors. The note was handwritten by Resident #40 and documented Staff J had not picked up his tray, "He made me wait. I don't need him in my room. He gave me guff about my BM today also." The resident had signed his name to the note.</p> <p>Staff B stated she had not discussed the events with either Resident #40 or with Staff J until 2/22/13, two days later. Staff B said she had the note since 2/20/13 but had not gotten to the resident. Staff B said the nurse on duty had written a notation on 2/20/13 that Resident #40 had yelled at Staff J and cursed at Staff J. Staff B said she interviewed Resident #40 on 2/22/13 and told him she was "disturbed" regarding his behavior and he needed to work on anger management.</p> <p>Staff B allowed Staff J to be on duty on the same hall as Resident #40 before an investigation was completed. Staff B said facility policy mandated a thorough investigation for any allegation of abuse up to and including suspension of staff until a determination could be made regarding the</p>			

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F 225	Continued From page 7 allegation.	F 225		4/8/13	
	<p>Staff B said she had not taken any action with Staff J. Staff B said she would now call Staff J back into the office for further interview 2 days after she received Resident #40's note of an allegation of possible abuse or neglect.</p> <p>The facility failed to take immediate action regarding an allegation of possible abuse or neglect to protect all residents when the facility had knowledge of an allegation.</p> <p>RESIDENT #109</p> <p>Refer to F-309</p> <p>A Minimum Data Set (MDS), an assessment tool, dated 1/15/13, documented Resident #109 required extensive assistance with activities of daily living including transfers into and out of her electric wheelchair. The resident was independent with eating after staff assisted her with set up.</p> <p>A care plan dated January 2013, documented Resident #109 had diagnoses to include [REDACTED] and [REDACTED]. Staff was to assist her by giving her a covered cup of coffee with a straw.</p> <p>On 2/28/13 at 12:40 a.m., Resident #109 was observed to have a cup of coffee with a plastic lid and straw on her over bed table. Resident #109 was able to maneuver her electric wheelchair to the nurses' station where staff would hand her a cup of coffee. She was not able to get coffee on her own from the coffee pot container.</p>				

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F 225	<p>Continued From page 8</p> <p>Resident #109 stated she was given coffee 2 days before which spilled on her leg causing a burn. Resident #109 said the staff person may not have put the lid on correctly and the coffee burned her upper thigh. Resident #109 said the burn was very painful at the time of the incident. Resident #109 also said she was having trouble with her electric wheelchair control making it hard to move the chair. Resident #109 was known to move about the facility in her electric wheelchair holding a cup of coffee on a daily basis.</p> <p>On 3/1/13 Staff E reported that Staff N reported he notified the physician on 2/26/13 regarding the burn.</p> <p>Multiple staff interviews on 2/28/13 found no staff had assessed the resident's burn area including how or why the incident occurred until 2/28/13.</p> <p>On 2/28/13 at 4:00 p.m., Staff E said Staff N did not fill out an incident report regarding the resident's burn as required by facility policy. Staff E said Staff N had not asked any further questions for the purposes of an investigation because the resident stated she had spilled coffee on herself "sometime during the day" on 2/26/13.</p> <p>On 2/28/13 Resident #109 was observed to be handed a cup of coffee by staff at the nurses' station while she was operating her wheelchair prior to the facility completing an investigation to determine the cause of the coffee spill on 2/26/13.</p> <p>The facility failed to immediately start an investigation to determine how or why the coffee</p>	F 225		4/8/13

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F 225	Continued From page 9 spill occurred on 2/26/13. Resident #109 continued to be provided with hot coffee from facility staff for two days before an investigation was started. During this time Resident #109 was given coffee, held the coffee in her hand over her lap area and operated her electric wheelchair with her other hand after reporting she had difficulty maneuvering the chair placing her at risk for further spills and possible burns.	F 225		4/8/13	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to honor 1 of 3 Sampled Residents (# 41) the choice of when to get up in the morning according to the Resident's preference of the 38 residents who were included in the Stage 2 Review. This failure placed the Resident at risk for diminished quality of life. Findings include: Resident #41 was re-admitted to the facility on [REDACTED] 2012 with multiple diagnoses to include	F 242	F242 Resident #41 has been interviewed regarding his preferences for getting out of bed and his care plan updated. Residents with preferences have the potential to be affected. Residents have been interviewed regarding preferences for getting out of bed in the morning and care plans updated as needed.		

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F 242	Continued From page 10 depressive disorder, and hypertension. On 2/22/13 Resident #41 reported s/he did not choose when to get up in the morning. When asked, Resident #41 reported s/he would prefer to get out of bed between 7:30 a.m. and 8:00 a.m., and stated s/he told staff of his/her request to get out of bed earlier. On 2/26/13 at 9:06 a.m., interview with Staff S and Staff V reported the resident prefers to get out of bed later in the morning, after s/he has had a bowel movement, because s/he requires a mechanical lift for transfers. On 2/26/13 at 9:10 a.m., interview with Resident #41 stated s/he does not prefer to have a bowel movement before getting out of bed, and stated s/he has tried over and over to have the staff get him/her up at an earlier time, but it does not happen and stated s/he gives up. Observations on 2/22/13 and 2/25/13 through 2/28/13, revealed the resident in bed pass 9:30 a.m. On 2-28-13 review of the record revealed a care conference note dated 2/22/13. According to the facility's form titled "Care Conference Summary Form", it documented, in part, "the resident would like to get up early." On 2/28/13 at 3:55 p.m., interview with Resident #41 stated the staff got him/her up at the same time, after 10 a.m. The Resident stated the whole day is over by the time the staff get him/her up in the morning, but there is nothing s/he can do about it.	F 242	Care Partner program will be initiated to assure resident preferences are being met. Random residents will be interviewed regarding their preferences using the facility QA Check up program. Staff was re-educated on the resident's right to make choices and preferences. Care Partner sheets and QA Check up will be trended by Administrator monthly and findings will be reviewed at the Performance Improvement Meeting for three months or until resolved to ensure continued compliance.	4/9/13

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NAME OF PROVIDER OR SUPPLIER TACOMA NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2102 SOUTH 96TH STREET TACOMA, WA 98444		
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F 242	Continued From page 11 On 2/28/13 at 4:02 p.m., interview with Staff W reported she was aware of Resident #41's request to get up earlier. Staff W reported it was the responsibility of each department to carry out each resident's request, and stated Staff G was present at the care conference, and had the responsibility to ensure Resident #41 got out of bed earlier. On 2/28/13 at 4:15 p.m., Staff G reported she did not recall Resident #41's request to get out of bed earlier. The facility's failure to allow Resident #41 the right to exercise his/her right of when to get out of bed in the morning placed the resident at risk for a diminished quality of life.	F 242		4/8/13	
F 250 SS=D	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 the facility failed to provide medically related social services to address discharge planning processes for 1 of 3 Sampled Residents (#17) reviewed for community discharge or assess, identify, and	F 250	F250 Resident #17 has been assessed for an appropriate discharge plan to lesser level of care and his care plan updated as needed. Resident #58 has had a thorough psychosocial assessment with the assistance of an interpreter; a		

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F 250	Continued From page 12 implement measures to attain the highest psychosocial well-being for 1 of 2 sampled residents (#58) reviewed for communication needs. These failures placed Resident #17 at risk for unmet discharge planning needs when he stated he wanted to return to a lesser care facility and placed Resident #58 at extreme risk for unmet needs when the resident could not communicate in English, had ongoing pain and distress, and suffered psychological harm when the resident attempted suicide while residing in the facility. Findings include: RESIDENT #17 Resident #17 was admitted to the facility [redacted] 12 from an assisted living facility with diagnoses to include [redacted] and [redacted]. A Minimum Data Set (MDS), an assessment tool, dated 12/12/12, documented Resident #17 had clear comprehension and a Brief Interview for Mental Status (BIMS) had a score of 13 out of 15 revealing he had good recall. Section Q0400 for, "Active discharge plan to return to the community" was checked as "Yes." A care plan dated 12/17/12, under "Behavior Symptoms" documented, "Resident will not self-isolate or over-eat due to [redacted], due date 2/15/13." The Discharge Plan section documented the resident will, "participate in what he needs to do to be able to return to Assisted Living." On 2/27/13 at 1:12 p.m., Staff AA said Resident	F 250	communication book has been provided for staff to communicate with resident regarding her ADLs and basic psychosocial needs; and the phone number for 24 over-the-phone interpreter services has been posted in the resident's chart. Social services will meet with resident and an interpreter monthly for three months and during quarterly care conferences to assure basic psychosocial and ADL needs are met. Residents with discharge plans have the potential to be affected. An audit was completed by Social Services of resident's discharge plans to assure appropriate interventions and placement goals.	4/8/13	

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F 250	<p>Continued From page 13</p> <p>#17 was admitted to the facility to "lose weight" before he could go back to his former facility. Staff AA said the resident was eating cookies and might not be meeting his goal.</p> <p>Staff AA said she had not had any contact with the former facility to discuss his return. Staff AA said it would be up to the former facility to call her about the resident's return. Staff AA said Resident #17 was "appropriate for long term care." Staff AA said Resident #17 just had a care conference and he did not want to "go anywhere else" so he would remain in the facility.</p> <p>On 2/28/13 at 11:40 a.m., Resident #17 was observed in the small TV room watching a video. His hair was greasy looking and he had multiple stains on his sweat pants and sweat shirt. Resident #17 said, "I want to go back to [name of facility]." Resident #17 said he understood his discharge plan included that he lose some weight to be able to return to his previous facility by the end of March 2013.</p> <p>Resident #17 said, "I don't like it here. I used to be able to go out at my old facility and have lunch. They set it all up for me. It is really hard for me to use the toilet here but I do the best I can. I really want to go back there."</p> <p>Resident #17 said he did not recall staff talking to him about going back to his old facility. He was waiting for someone to tell him the plan.</p> <p>Record review found no specific notes found under "Social Services" regarding a discharge plan. A "Care Conference Summary Form" dated 2/05/13, had nine areas filled out. The section for</p>	F 250	<p>Residents with ESL have the potential to be affected. Residents with ESL have had a thorough psychosocial assessment with the assistance of an interpreter for family; a communication book has been provided for staff to communicate with residents regarding their ADLs and basic psychosocial needs; and the phone number for 24 hour over-the-phone interpreter services has been posted in the resident's chart.</p> <p>Social services will meet with residents, family and interpreter as needed, during the initial quarterly care conferences, to discuss and document appropriate discharge plans and to assure basic psychosocial and ADL needs are met.</p> <p>Social Services has been re-educated by the Administrator on the need to follow up on residents' discharge preferences as appropriate for their level of care and barriers.</p>	4/8/13

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F 250	<p>Continued From page 14</p> <p>"Discharge Plan" was blank. Social Service staff reported no need to contact his former facility to discuss his discharge planning needs because he would remain at the facility.</p> <p>RESIDENT #58</p> <p>Resident #58 was admitted to the facility in [REDACTED] 2012 with diagnoses to include [REDACTED] diabetes, [REDACTED] congestive heart failure, [REDACTED] and [REDACTED]. English was not her primary language.</p> <p>Resident #58 had lived at home until she was hospitalized in June 2012. Review of hospital notes dated 6/28/12, documented through the use of a translator, found she was aware she was being treated in a hospital. The resident said she heard what sounded like the voice of Jesus Christ. Her short term memory was impaired. The hospital plan was to periodically check her ability to understand her condition and what care she wanted through the use of a translator.</p> <p>Resident #58 was started on [REDACTED] medication and transferred to the facility.</p> <p>A Minimum Data Set (MDS) an assessment tool dated 1/24/13, for Resident #58, documented it was very important for the resident to attend religious services and to go outside when the weather was good. The MDS documented the resident responded to simple communication only.</p>	F 250	<p>Staff has been educated on the use of the communication book, 24 hr interpreter phone line, and the use of Social Services in regards to meeting residents' communication needs.</p> <p>Social Services will randomly audit resident discharge plans monthly for three months to assure follow up on resident's discharge preferences as appropriate for their level of care and barriers. Copy of audits with findings will be provided to the Administrator for review and follow up as necessary. Issue will be reviewed at monthly Performance Improvement Meeting for three months or until resolved to ensure continued compliance.</p>	4/9/13
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F 250	<p>Continued From page 15</p> <p>A care plan dated 2/04/13, documented her long term goal as, "Resident will not become tearful or have sad expression." Approaches included to "Always encourage to be in common areas when up in wheelchair" and "In the event the resident is tearful or behaviors increase contact social services and nurse to schedule people to come in to interpret for resident."</p> <p>There was no specific care plan to address non-English speaking methods of communication to meet her needs.</p> <p>Record review of care directives used by the nursing assistants dated 2/21/13, documented, "little English." The directive had "Understands" and "Does not understand" "Speech Clear" and "Unclear" all circled. It was not known what the document directed the caregivers to do regarding communication for the resident.</p> <p>On 3/01/13 at 10:00 a.m., Resident #58 was observed lying on her bed on the floor. She was wearing only a top and underwear. Resident #58 had a one to one caregiver who was sitting in a chair next to the resident's head. The caregiver (Staff KK) was watching a TV comedy show not in the resident's language.</p> <p>Staff KK said Resident #58 could say the words, "Change diaper" regarding toileting. Staff KK said Resident #58 could, "really get angry and throw herself on the floor. We don't know why she is doing this behavior."</p> <p>When greeted, Resident #58 said, "Sore throat, sore throat!" The resident then held her arm and</p>	F 250	<p>Residents admitted with ESL will be audited to assure a thorough psychosocial assessment has been completed with the assistance of an interpreter or family to ensure their basic psychosocial needs and ADLs have been met on a daily basis. A copy of audits with findings will be provided to the Administrator for review and follow up as necessary. Issue will be reviewed at monthly Performance Improvement Meeting for three months or until resolved to ensure continued compliance.</p>	4/8/13

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F 250	Continued From page 16 stated, "Hurt, hurt." Staff KK reported the resident had not eaten breakfast or had any medication. A piece of paper posted above the resident's bed had the translated words, "Medicine, hungry, drink, pain, change brief" taped above bed. The following chart notes documented Resident #58's condition over 14 months with no interpreter involved as follows: 7/22/12 - Resident #58 was found on the floor. 7/24/12- Note to add behavior monitor for tearful and sad expression. 7/26/12- Non-English but can do some non-verbal gestures. On [REDACTED] 12 Resident #58 was re- admitted to the hospital with a [REDACTED] infection and [REDACTED] [REDACTED] after facility staff noted she was unresponsive and sent her to the hospital. The resident was re-admitted to the facility on [REDACTED] 12 with an IV to administer antibiotics for a [REDACTED] and a Foley catheter for urinary drainage. 8/17/12- Late entry for 8/16/12, Resident pulled out catheter. Writer was showing resident catheter and trying to talk to her about it (in English). Resident stated, 'No, no' Foley left out. 8/21/12-Resident pulled out her IV. IV antibiotic stopped. 8/1/12 (IV team documentation)- Patient unpredictable with behaviors ...Recommend placement of PICC line (IV) at hospital. (the PICC	F 250		4/3/13	

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F 250	Continued From page 17 line was replaced).	F 250		4/8/13
	<p>8/23/12- Attempts at pulling at tubing and IV ...became combative when staff asked her not to pull at PICC.</p> <p>8/24/12-(evening) became agitated when told not to pull at PICC line</p> <p>8/31/12- called [friend of resident] to get verbal consent to give [redacted] (for agitation). Found on floor on stomach, as intentionally done in past, resisted staff when tried to get up. Started on digoxin (heart medication) today.</p> <p>9/09/12-Resident started to hit (nurse attempting to give IV meds) tried to bite arm, stating 'no' to IV, crying, able to hook up (and administer) IV.</p> <p>9/10/12- (Resident) shouting for something nobody can understand. {Chart notes indicate the resident had multiple medication changes including several antibiotics with potential side effects, with no discussion with the resident with a translator to explain or offer her a choice}</p> <p>9/29/12- Resident stating, 'go home, go home' ...continue to monitor</p> <p>9/30/12-Resident rubbing right leg and grimacing medicated with [redacted] (a narcotic).</p> <p>10/09/12- Increased [redacted]</p> <p>10/10/12 - Resident refused morning and noon meds.</p>			

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F 250	<p>Continued From page 18</p> <p>On 10/16/12 Resident #58 was re-admitted to the hospital for 10 days for a potassium level "too high to manage in the nursing home."</p> <p>█/12- Re-admit female, non-English speaking, able to smile and nod.</p> <p>11/02/12- found on floor, (staff) got up from floor ...decreased appetite. Bed moved to the floor.</p> <p>11/05/12- 3:00 a.m., Nurse found (resident) nude on bed on the floor. At 8:00 p.m., crying and pounding on leg; █ given. Continues to refuse to eat ...likes to lie down more often now. Gets upset and angry when try to put her on air mattress.</p> <p>11/14/12- Throwing things from closet on floor, this is not unusual.</p> <p>Chart notes continued to document Resident #58's behaviors, gestures of pain and multiple attempts at exiting, and hitting staff when they tried to redirect the resident from leaving the facility.</p> <p>On 11/15/12, the facility documented the person they had listed as the Power of Attorney (POA) was only a friend and did not have authority to make decisions regarding medication or treatment changes as the facility had been doing since her admission.</p> <p>On 11/16/12, chart notes documented the Social Service Director (SSD) had her personal friend come and speak to Resident #58. During the "interview" the resident stated she had an ongoing upset stomach and burning in her throat</p>	F 250		4/9/13
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F 250	<p>Continued From page 19 and chest. The resident was told through the staff member's friend she was receiving medications for her symptoms. Resident #58 stated she had no desire to eat and the SSD's friend told her "not to be so sad and upset."</p> <p>On 12/02/12, chart notes documented Resident #58 was moaning and crying "pointing to her head." The resident had a fever of 102.1 degrees. Chart notes documented staff gave her crushed Tylenol and put her to bed to, "maybe pinpoint source of pain." There was no notification to the physician at this time. Staff then had a male staff person who was cleaning the floors, ask the resident in her language, what was wrong and "she would not answer."</p> <p>On 12/03/12, Resident #58 again had a fever of 102 degrees. Staff received an order to get a urine sample by catheterizing the resident.</p> <p>The chart notes continued to document episodes of pain, distress and refusals to eat. According to the facility documentation and interviews, staff had no translator present to interpret Resident #58's needs.</p> <p>On 1/21/13, chart notes documented Resident #58 attempted suicide by tying her privacy curtains together and wrapping them around her neck. The notes documented the crisis team interpreter translated Resident #58 to say the resident tried to kill herself because she was "in prison" when no one understood her needs.</p> <p>The facility placed Resident #58 on one to one suicide watch on which she remains currently.</p>	F 250		4/8/13

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F 250	<p>Continued From page 20</p> <p>On 1/30/13, chart notes documented, "Resident continues on 1:1 monitor. Resident had angry outburst, cause unknown. Resident would not speak English."</p> <p>On 2/06/13, chart notes documented, "Resident speaking her language and when asked to speak English, she stated, 'Shoot me.'</p> <p>Record review of psychiatric notes for Resident #58, dated 2/01/13, documented: "Exam, no interpreter. Marginal exam secondary to language. Must assume she is suicidal or possibly homicidal."</p> <p>Record review found only two visits with a translator from an official service present prior to the suicide attempt.</p> <p>On 2/27/12 at 2:00 p.m., Staff JJ said Resident #58 required 1:1 supervision 24/7 after the resident attempted to kill herself in the facility.</p> <p>At 3:00 p.m., Staff BB said staff used gestures try to see what was wrong with the resident. Staff BB said she had only seen the interpreters in several times since the resident's admission, and, "The family does not visit that much." (Resident #58 had no family).</p> <p>On 2/28/13 at 1:10 p.m., Staff B said in regards to the suicide attempt, "She can't speak English so we do not know the reason."</p> <p>On 3/04/13 at 9:30 a.m., Staff AA reported she notified official translator services to schedule times for interpreters to assist the resident "as needed." Staff AA noted the service was set up</p>	F 250		4/8/13	

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F 250	Continued From page 21 only twice prior to the suicide incident in January 2013.	F 250		4/9/13
	<p>When asked how the facility determined the resident's needs including psycho-social issues, Staff AA and Staff W said Resident #58's friend came the first month or so of the resident's admission (June 2012). By September the friend could no longer visit very often and came in the evenings.</p> <p>Staff AA and W said there had been confusion regarding the friend who turned out not to be the Power of Attorney so the facility was seeking guardianship.</p> <p>Staff AA and W reported they were able to determine what foods the resident wanted by talking to a case manager who spoke the resident's language. This was noted to be done in November 2012; five months after the resident had resided in the facility.</p> <p>Staff AA and W reported the resident liked reading her Bible. They were not sure if the resident would be capable of going to a religious service or not. They stated they could ask her if she wanted to go to a service outside of the facility.</p> <p>Staff AA said she was not aware of any type of communication tool used by staff. Staff AA reported Resident #58 would be transferred to an adult family home that spoke her language to better meet her needs once her wounds were healed.</p> <p>On 3/04/13 at 10:30 a.m., Staff I said staff had a</p>			

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F 250	<p>Continued From page 22</p> <p>one page sheet (found on the computer) of words translated into English such as pain and hungry. There was no communication board, book or method of regular translation developed for Resident #58.</p> <p>Staff I said an intepreter recently translated Resident #58 had nothing to offer spiritually so she gave up going to service. Staff did not have a plan to address this need. Staff I reported the resident would remain in the facility long term and there were no plans to discharge her back to the community.</p> <p>The facility failed to provide medically related social services to thoroughly identify the resident's needs (pain, food preferences, spiritual distress) when English was not her primary language yet insisted she "Speak English". Activities of daily living and basic psycho-social needs assessments were not completed when the resident had no way to express those needs causing her anguish to the point of attempted suicide.</p>	F 250		4/8/13
F 253 SS=C	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and</p>	F 253		

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F 253	Continued From page 23 maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to provide maintenance services to ensure a comfortable and homelike environment in 4 of 4 Halls (Halls A, B, C & D) and in the Laundry Room. This had the potential to decrease resident quality of life and/or prevent proper sanitization of all counter top surfaces and spread infectious agents. Findings include: During environmental rounds on 3/4/13 beginning 9:27 a.m. the following areas were in need of repair that included damaged Formica countertops with areas of unfinished wood exposed: RESIDENT ROOMS DAMAGED FORMICA COUNTERTOPS: Room 6: The edges of the sink countertop in the room did not have Formica covering one foot in length on the left side and approximately six inches in the front. Room 22: The edge of the sink counter top approximately two inches in length did not have Formica covering and exposed unfinished wood beneath. Room 35: Approximately four inches along the edge of the left corner of the sink countertop was	F 253	F 253 The Formica countertops in resident rooms 6, 22, 35, 38, 40, 41, 45, 55, and 96 have been repaired. The venetian blinds in resident rooms 88, 96 and 94 have been replaced. The rubber molding in room 6 has been repaired. The walls in resident rooms 57, 82, 86, 88 and 96 have been repaired and painted. The countertop in the restorative department has been repaired. The depressed circular area in the hallway floor outside room 87 has been repaired. The countertop in the A/B nurses' station has been repaired. The countertop in the dining room has been repaired.	4/8/13	

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F 253	Continued From page 24 missing Formica.	F 253	Room 16 has been repaired and painted.	4/8/13
	<p>Room 38: Approximately two feet of Formica edging that surrounded the counter on the left side of the sink was missing and exposed unfinished wood.</p> <p>Room 40: The entire Formica edge that measured approximately two feet long was missing from the counter top that surrounded the sink in the room.</p> <p>Room 41: The Formica edge on the right side of the sink countertop in the room that measured approximately 1.5 feet long was missing.</p> <p>Room 45: A triangular corner edge of the sink countertop in the room was missing Formica covering that measured approximately 2 inches wide.</p> <p>Room 55: The Formica edge of a counter located on the left side of the room upon entering the doorway was missing that measured approximately one foot long and 1.5 inches high.</p> <p>Room 96: the table next to the wardrobe in the room had missing a piece of Formica edge that measured approximately 1.25 inches high and wide.</p> <p>RESIDENT ROOM VENETIAN BLINDS Each resident room contained two blinds that covered a very large window on one wall. Each blind measured approximately 6 feet wide and five feet high.</p> <p>Room 88: Multiple ends of venetian blinds were</p>		<p>The fan in the laundry room has been cleaned.</p> <p>The countertop in the laundry folding area has been repaired.</p> <p>Potentially affected areas of the facility including countertops, blinds, molding, floors and walls have been audited and repaired and/or replaced as needed.</p> <p>Maintenance Director or designee will continue to do weekly environmental rounds to identify areas needing repair and/or replaced.</p> <p>Administrator will review environmental rounds monthly any findings will be reviewed at monthly Performance Improvement Meeting for three months or until resolved to ensure continued compliance.</p>	

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F 253	Continued From page 25 bent on the center lower portion of both blinds.	F 253		4/8/13
	<p>Room 96: two edges of venetian blind that measured approximately six inches long were bent 90 degrees and faced directly into the room. There were six additional blind edges that were bent in the center of the two large blinds.</p> <p>Room 94: On the left side of the right venetian blind the ends of six blind slats were bent.</p> <p>On 3/4/13 at approximately 10:00 a.m. Staff A reported the facility replaced many venetian blinds that were damaged throughout the year.</p> <p>RESIDENT ROOM WALLS</p> <p>Room 6: Rubber molding that measured approximately one foot long on the right side of the bathroom door in the resident's room peeled away from the wall and exposed unfinished wallboard beneath.</p> <p>Room 57: There were multiple black marks on the left wall upon entering the room that measured approximately four feet long and covered an area two feet high.</p> <p>Room 82: The blue wall on the right side upon entering the room had a black mark that measured approximately four feet long and multiple small chipped areas of unpainted wallboard that exposed wallboard beneath.</p> <p>Room 86: There were long black marks on the wall on the right side upon entering the room that measured approximately three feet long. Some scrapes did not have wall surface and exposed wall board beneath.</p>			

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F 253	Continued From page 26	F 253		4/8/13
	<p>Room 88: There were darkened marks on the left wall upon entering the room that covered an area that measured approximately three feet long and one foot high.</p> <p>Room 92: An area that covered approximately two feet long and 18 inches high had multiple marks scrapes on the left beige colored wall upon entering the room. The scrapes exposed unpainted white wallboard beneath.</p> <p>COMMON DAMAGED AREAS</p> <ol style="list-style-type: none"> 1. The restorative nursing department at the end of the D Hall had a countertop whose left corner did not adhere but peeled away from the surface. 2. The middle of the linoleum floor in the hallway outside Room 87 had a depressed circular area with cracks that measured approximately three inches awide. The depression sunk approximately 1/4 of an inch in depth. The depression created an uneven surface for residents, staff and visitors to walk across. 3. The A/B Hall nursing station counter located on the left upon entering swinging doors did not have formica covering an edge on the front that measured approximately a total of 3.5 feet in length. 4. A long counter in the Main Dining Room adjacent to the wall of the kitchen was missing Formica in two areas. One area that measured approximately six inched on one edge and another area that measured approximately two inches across exposed unfinished wood beneath. 			

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F 253	<p>Continued From page 27</p> <p>5. Room 16 Dining Room on the A Wing had multiple large scrapes on blue walls that exposed white wall board beneath.</p> <p>On 3/4/13 at 10:00 a.m. Staff A reported some rooms had been renovated a little at a time to replace damaged areas and paint. Staff A reported more upgrades were planned for next year. The surveyor requested a list of rooms the facility planned to renovate during the rest of the year.</p> <p>During a meeting on 3/4/13 at 4:45 p.m. Staff A reported the facility did not have specific rooms identified for renovations during the year but selected rooms that needed renovation the most. Staff A reported facility maintenance staff completed the work when able.</p> <p>LAUNDRY ROOM During laundry rounds on 3/4/13 beginning 11:52 a.m. a fan located on an upper wall near the ceiling in the laundry sorting room had a visible heavy coat of dust on the cover and blades. A piece of black tape covered the switch on the switch plate. Staff GG reported staff never turned the fan off.</p> <p>On 3/4/13 at 12:24 p.m. the laundry folding room contained a table covered with a Formica countertop that measured approximately 10 feet long. The front edge of the long table, approximately three inches deep, was partially covered with a dense, firm substance. There were exposed areas of unfinished wood covering approximately 5 feet in length across the front edge. At this time, Staff GG reported the edge of the wood sometimes caught on his/her</p>	F 253		4/8/13

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F 253	Continued From page 28 fingernails. Staff HH did not know what the firm substance was and confirmed the covering on the table needed to be replaced.	F 253		4/8/3
F 278 SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 278	<p>F278</p> <p>Resident #97 has had a oral/dental assessment, modification of MDS and care plan has been updated as needed.</p> <p>Residents have received an oral/dental assessment, modification of MDS and care plans have been updated as needed.</p> <p>The MDS Nurse was re-educated by the MDS Coordinator on how to perform a thorough oral assessment and accurately document on the MDS to assure appropriate care planning and follow up.</p>	

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F 278	<p>Continued From page 29</p> <p>by:</p> <p>Based on observation, interview and record review it was determined that the facility failed to accurately assess the dental status for 1 of 3 Sampled Residents (# 97) reviewed for dental conditions of the 38 residents who were included in the Stage 2 review. This prevented timely referral for dental care and had the potential to place this resident at risk for weight loss and/or oral or systemic infection.</p> <p>Findings include:</p> <p>On 2/22/13 at 3:20 p.m. Resident #97 displayed discolored and broken teeth during conversation with the surveyor.</p> <p>On 3/1/13 at 10:45 a.m., when asked if he/she had seen a dentist the resident reported "I shouldbecause I have cavities." The resident agreed to allow staff to look at his/her teeth.</p> <p>Later on 3/1/13 at 11:26 a.m. both the surveyor and Staff Q looked inside Resident #97's mouth. An upper right molar appeared darkened and decayed and a second molar appeared to be broken. Six lower front teeth appeared either broken or worn down and blackened in the center. There were missing teeth in the upper center portion of the mouth. It did not appear the condition of the resident's mouth recently developed.</p> <p>When Staff Q asked the resident if he wanted to see a dentist he/she reported "they hurt". Staff Q reported the resident had not previously complained of oral pain.</p>	F 278	<p>Nurse Managers will perform random audits of residents' dental/oral condition related to the MDS assessment weekly for four weeks, then monthly for three months to assure accurate documentation, appropriate care planning and follow up.</p> <p>Copy of audits will be provided to the DNS for review and follow up as necessary. Issues will be reviewed at monthly Performance Improvement Meeting for three months or until resolved to ensure continued compliance.</p>	4/8/13	

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F 278	<p>Continued From page 30</p> <p>A Resident Admission Record identified Resident #97 admitted to the facility on 6/17/10 6/17/10. The facility conducted dental assessments using Minimum Data Set Assessments (MDS, an assessment tool) which contained a section to code "obvious or likely cavities or broken natural teeth".</p> <p>A Quarterly MDS assessment identified the resident did have likely cavities or broken teeth dated 5/30/12 at that time. The record did not identify staff referred the resident for a dental consult.</p> <p>Later assessments that included an annual MDS assessment dated 8/20/12 and quarterly MDS assessments dated 11/14/12 and 2/5/13 did not identify the resident had dental decay or broken teeth and coded "none of the above were present."</p> <p>On 3/1/13 at 11:52 a.m., when asked how staff conducted oral assessments, Staff R reported another staff member who was not currently in the building completed the assessment and did not know how it was done. Staff R reported, when conducting oral assessments, she would look inside resident's mouths.</p> <p>On 3/1/13 at 11:56 a.m. Staff I reported the MDS assessment would generate the need for a dental referral.</p> <p>Failure to accurately assess Resident #97's current oral condition using the MDS tool since 8/20/12 prevented the MDS to trigger and prompt staff to timely update an appropriate plan of care to meet the resident's dental concerns.</p>	F 278		4/8/13

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F 278	Continued From page 31 Refer to F 412 for failure to timely refer for a dental consult.	F 278		4/8/13	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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. 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). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to develop and/or revise comprehensive care plans that consistently included measurable goals and objectives and interventions for 4 of 29 Sampled Residents (#'s 32, 47, 67, & 100) reviewed for care plans of the 38 residents who were included	F 279	F279 Resident #100 is no longer in the facility. Resident #32, #47 and #67 have had their comprehensive care plans reviewed and/or revised as needed to assure all necessary care needs are met. Residents with comprehensive care plans have the potential to be affected. Resident charts were audited to assure development and/or revision of resident care plans. RCM's and MDS nurse have been reeducated by DNS on the need to develop and/or revise resident comprehensive care plans to assure all necessary care needs are met.		

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F 279	<p>Continued From page 32 in the Stage 2 review. Failure to establish/revise comprehensive plans of care that met each resident's needs had the potential to place residents at risk to not receive all necessary care and/or decline in condition.</p> <p>Findings include:</p> <p>RESIDENT #47 On 2/25/13 at 1:30 p.m. Resident #47 lay in bed on top of covers fully dressed and slept. On 2/26/13 during the breakfast meal the resident sat in bed, appeared comfortable and voiced no concerns.</p> <p>A "Resident Admission Record" identified Resident #47 currently admitted to the facility on 1/19/13 following a [REDACTED] hospitalization. Diagnoses included [REDACTED] and [REDACTED]. The primary admission diagnoses identified the resident required rehabilitation.</p> <p>Nursing documentation identified on 2/1/13 the resident went to the hospital with [REDACTED]. The resident returned to the facility on [REDACTED] 13. A physician visit note dated 2/14/13 documented Resident #47 required hospitalization due to a slight increase in [REDACTED]. A nutritional assessment conducted [REDACTED] 13 after the resident returned to the facility documented the resident had significant weight loss related to hospital treatment for [REDACTED] (a [REDACTED] bandage on [REDACTED]).</p> <p>On 1/9/13 the physician ordered staff to monitor the resident's lower extremities for increased [REDACTED] and weeping and to measure the</p>	F 279	<p>Nurse Managers will randomly audit resident charts weekly for 4 weeks then monthly for two months to assure development and/or revision of resident comprehensive care plans.</p> <p>Copy of audits will be provided to the DNS for review and follow up as necessary. Issues will be reviewed at monthly Performance Improvement Meeting for three months or until resolved to ensure continued compliance.</p>	4/18/13	

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F 279	<p>Continued From page 33</p> <p>resident's legs weekly for [REDACTED]. The physician also ordered an [REDACTED] medication given to treat [REDACTED] and a diuretic given twice a day. A psychiatrist evaluated Resident #47 on 1/18/13 and wrote a note it was unclear why the resident took the anti-psychotic medication and requested additional history information to determine what to do.</p> <p>A Minimum Data Set (MDS, required assessment tool) dated 1/22/13 for Resident #47 identified multiple care areas of concern noted and included reasons why each area of concern required a plan of care. Areas included the following:</p> <ul style="list-style-type: none"> · Impaired activities of daily living (ADL) function; · At risk for injury of related to falls with generalized weakness and decreased safety awareness · Hydration status at risk due to medical condition · Pressure ulcer risk; admitted with [REDACTED] · [REDACTED] medication use <p>A "Preliminary Care Plan" dated 1/9/13 listed the above areas of concern and added additional concerns that included exacerbation of respiratory condition, diabetic management, impaired communication and activity tolerance. The preliminary care plan did not specifically identify how the resident's communication was impaired, what the respiratory condition was or include specific interventions for staff to follow related to any of the additional identified concerns.</p>	F 279		4/8/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505154	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2013
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NAME OF PROVIDER OR SUPPLIER TACOMA NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2102 SOUTH 96TH STREET TACOMA, WA 98444
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F 279	<p>Continued From page 34</p> <p>Resident #47's medical record did include a care plan titled "Mood State". The mood state care plan did not include an intervention specifically related to use of an anti-psychotic medication that identified the need to obtain additional medical psychiatric history for the psychiatric consultant to determine if an anti-psychotic medication was needed or could be dose reduced.</p> <p>On 2/26/13 at 1:07 p.m. Staff W reported he/she would attempt to obtain further medical records and was involved in discharge planning to assist Resident #47 with alternate discharge placement.</p> <p>Resident #47 had specific medical concerns that required careful monitoring and care planning to assist with fluid management to prevent further pulmonary and skin complications. The MDS assessment identified this as an area of concern due to chronic [REDACTED], history of [REDACTED] and [REDACTED] use.</p> <p>The resident's record did not contain a plan of care with specific nursing interventions for edema assessment that identified what tools were used to assess and how staff would determine if the resident's condition declined or if the resident needed further medical attention.</p> <p>On 2/28/13 at 4:47 p.m. Staff R reported if a resident had [REDACTED] a care plan for alteration in skin or alteration in health issues related to heart failure should be developed. Staff R also reported the temporary (preliminary) care plan was good for only 14 days and MDS nurses completed admission care plans. Staff R reported staff were behind on completing care plans.</p>	F 279		4/8/13
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F 279	<p>Continued From page 35</p> <p>On 2/28/13 at 5:20 p.m., Staff F reported a care plan had not been generated for Resident #47 yet. Later at 5:30 p.m., Staff R also reported Resident #47's care plan had not been completed.</p> <p>Resident #47 readmitted to the facility on [REDACTED] 13. The resident's record did not contain a comprehensive care plan for staff to follow that addressed specific medical needs near the conclusion of survey on 3/4/13, more than three weeks later. Failure to timely complete a comprehensive plan of care had the potential to place this resident at risk for decline in medical condition and/or to not reach the highest practicable level of physical or psychosocial functioning and had the potential to delay discharge.</p> <p>RESIDENT #100 Resident #100 admitted to the facility on [REDACTED] 13 with multiple diagnoses to include [REDACTED]</p> <p>On 2/27/13 review of the record revealed Resident #100 had [REDACTED] on Mondays, Wednesdays, and Fridays at an outside facility. Further review of the record revealed that a [REDACTED] care plan had not been developed for this resident.</p> <p>Review of the facility's "Dialysis Protocol" dated, March 2012 revealed, in part, "A plan of care addressing the issues surrounding hemodialysis will be developed."</p>	F 279		4/8/13

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F 279	<p>Continued From page 36</p> <p>On 2/27/13 at 1:51 p.m., Staff F confirmed that a dialysis care plan had not been developed for this resident.</p> <p>Failure to develop a plan of care addressing risk factors and potential complications related to dialysis treatment, placed Resident #100 at risk to receive less than adequate care.</p> <p>RESIDENT #32 Resident #32 was admitted to the facility on [REDACTED] 11 with multiple diagnoses to include [REDACTED] [REDACTED] and congestive heart failure.</p> <p>Record review revealed a "Hospice Certification of Terminal Prognosis" dated 11/16/12. Review of the record revealed a care plan had been developed by hospice which depicted the care and services hospice would provide. Further review of the record did not contain evidence the facility and hospice jointly developed a plan of care that guided both providers identifying which provider was responsible for various aspects of Resident #32's care.</p> <p>On 2/27/13 at 10:26 a.m., interview with Staff B and staff F confirmed the facility failed to develop a plan of care in conjunction with hospice, to detail care to be provided by the facility, hospice or both.</p> <p>The facility's failure to coordinate a plan of care with hospice to identify the care to be provided by either hospice or the facility, placed Resident #32 at risk to have unmet care needs.</p> <p>RESIDENT #67 Resident #67 was admitted to the facility on</p>	F 279		4/8/13

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F 279	Continued From page 37 #12 with multiple diagnoses to include hypothyroidism.	F 279		4/3/13
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p>	F 280	<p>F280</p> <p>Resident #101's restorative care plan has been revised to reflect residents change in ambulation status.</p>	

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F 280	Continued From page 38	F 280		4/8/13	
	<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 the plan of care was revised and/or developed within required time frames for 1 of 38 Sampled Residents (#101) reviewed for comprehensive care plans. This failure placed residents at risk for unmet needs.</p> <p>Findings include:</p> <p>RESIDENT #101 Resident #101 was admitted to the facility in 2011 with diagnoses to include [REDACTED] and [REDACTED].</p> <p>A Minimum Data Set (MDS) an assessment tool, dated 1/14/13, documented Resident #101 required extensive to total assistance with her activities of daily living. The MDS documented the resident had 6 days of walking sessions during the 7 day observation period.</p> <p>A care plan dated 2011, documented the resident was to participate in a restorative therapy program that included walking 30-50 feet in parallel bars and to stand in the standing frame up to 15 minutes as tolerated, 6 times a week.</p> <p>The "Restorative Flow Sheet" had the letters "D/C" (discontinue) written on the sheet on 2/26/13 to stop the walking and standing frame exercises. The sheet documented 9 entries of</p>		<p>Residents with restorative programs have the potential to be affected. Resident restorative programs have been reviewed and revised as needed to reflect any changes in resident condition to assure current needs are met.</p> <p>Restorative NAC's were educated by the DNS on the use of the early warning tool (Stop and Watch) to better communicate changes in resident conditions to LN's to assure resident needs are met in a timely manner and to assure resident restorative care plans and programs are updated as needed.</p> <p>LN's have been reeducated by the DNS on the use of the Early Warning Tool and the importance to respond in a timely manner to assure resident needs are met.</p>		

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F 280	Continued From page 39 pain and 4 refusals during the exercise program for the month of February 2013.	F 280	Early Warning Tool will be reviewed at the weekly restorative meeting to assure resident needs are met in a timely manner and to assure resident restorative programs and care plans are updated as needed.	4/8/13
	On 2/26/13 at 11:30 a.m., Staff Z said Resident #101 had not been ambulating in a "long time." Staff Z said Resident #101 could not fully extend her legs to stand. Staff Z said, "We report if residents have pain when they do their exercise program. We had to discontinue (Resident #101) because she had pain when standing. Her knees " There was no revision to the plan of care to address a change in the resident's status that included discontinuing her ambulation program that she had not participated in for some time or what the new plan was to deliver a revised rehab program including monitoring for pain during exercise.		Copy of audits will be provided to the DNS for review and follow up as necessary. Issues will be reviewed at monthly Performance Improvement Meeting for three months or until resolved to ensure continued compliance.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to consistently clarify and/or follow physician orders for either medications or edema monitoring for 2 of 38 Sampled Residents (#s 56 & 144) of the 38 sampled residents who were included in the Stage 2 review. This resulted in missed breathing treatments for Resident #144 and inconsistent	F 281	F281 Resident #144 is no longer in the facility. Resident #56 has had edema measurements.	

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F 281	Continued From page 40 monitoring of edema for Resident #56.	F 281		4/8/13
	<p>Findings include:</p> <p>RESIDENT #144</p> <p>The Center for Medicare and Medicaid Services State Operating Manual, dated January 2011, defines "professional standards of quality" as services provided according to accepted standards of clinical practice. Recommended practices to achieve desired resident outcomes may be found in clinical literature, current manuals or textbooks, or published by a professional organization.</p> <p>According to Smith, Duell and Martin, Clinical Nursing Skills, Sixth Edition, pages 518-521, nurses are to administer medications as ordered by the physician</p> <p>Breathing Treatment: Refer to F 328 for resident observation, medical history, additional record review and interview.</p> <p>Hospital discharge reconciliation medication orders dated 2/21/13 identified to administer breathing treatments to Resident #144 every four hours while awake. Transcribed facility February 2013 Physician Orders and medication sheets identified for staff to provide breathing treatments every four hours only as needed.</p> <p>On 2/27/13 at 11:25 a.m. Staff I reported admission staff checked admission orders then gave checked orders to medical records to type up facility orders and medication records. Staff I also reported completed facility orders and</p>		<p>Residents with respiratory treatments have the potential to be affected. Admissions in the past thirty days have been audited by Nurse Managers to assure accurate transcription of hospital orders and corrected as needed.</p> <p>Residents with orders for edema measurements have the potential to be affected. Nurse Managers have audited residents with orders for edema measurements to assure consistent monitoring.</p> <p>Admission nurses and RCM's have been reeducated by DNS on facility policy to have two nurses reviewing hospital and physician orders at time of admission to assure accurate transcription of orders.</p> <p>Medical Records have been educated by the DNS on the need to clarify hospital physician orders with facility admitting nurse to assure accurate transcription.</p>	

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F 281	<p>Continued From page 41 medication records were then to be reviewed by two nurses for accuracy.</p> <p>Facility February 2013 Physician Orders only contained the signature of one nurse who reviewed the orders and not the signature of a second nurse.</p> <p>On 2/27/13 at 11:25 a.m. Staff I confirmed facility generated physician orders did not match the frequency breathing treatments were ordered on hospital discharge orders. Staff I confirmed the order was not accurately transcribed and then clarified the treatment order with the physician and reported the physician wanted Resident #144 to receive breathing treatments routine every four hours while awake and not as needed.</p> <p>As a result of failure to transcribe breathing treatment orders accurately, Resident #144 did not receive breathing treatments every four hours as ordered since admission on 2/27/13 until 12:00 p.m. on 2/27/13.</p> <p>██████████ Hospital discharge reconciliation medication orders dated 2/21/13 identified for staff to administer 20 mg of ██████████ daily. The order also indicated to taper the medication by 2 mg every other day.</p> <p>A Resident Admission Record identified Resident #144 admitted to the facility on ██████████ 13 at 3:22 p.m.</p> <p>On 2/27/13 at 11:25 a.m., when asked what day prednisone dose tapering should begin, Staff I reported he/she would need to know what the</p>	F 281	<p>LN's were educated by the DNS on re-offering edema measurements if not completed or if resident refuses to assure consistent monitoring.</p> <p>During completion of admission audit by DNS and RCM, hospital physician orders will be reviewed and compared to facility physician orders to assure accurate transcription.</p> <p>RCM's will randomly audit edema monitoring sheets weekly for four weeks then monthly for two months to assure completeness of edema measurements.</p> <p>Copy of audits will be provided to the DNS for review and follow up as necessary. Issue will be reviewed at monthly Performance Improvement Meeting for three months or until resolved to ensure continued compliance.</p>	4/8/13
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F 281	Continued From page 42 taper dose pattern was when the resident was in the hospital. Staff I reported facility physician orders should have been clarified with the physician. Inhaled Medications: Hospital discharge reconciliation medication orders for Resident #144 dated 2/21/13 identified the physician ordered for the resident to receive two different inhalers. One inhaler was ordered given once a day and the second inhaler twice a day. Neither order identified how many puffs the physician wanted the resident to inhale each time. On 2/27/13 at 11:25 a.m. Staff I reviewed the resident's record and reported the order needed to be clarified and the number of puffs should be identified on the orders. RESIDENT #56 Refer to F 329 for resident observations and medical history. On 6/1/08 Resident #56's physician directed staff to obtain [REDACTED] measurements on the 20th of every month. The resident's record contained an "[REDACTED] Measurement Flow Sheet" that identified for staff to measure the resident's mid arch on right and left feet, right and left feet above the ankle bone and mid-calf measurements of both legs. The resident's record did not contain evidence staff obtained edema measurements during January 2013, February 2013 or for three months between June 2012 and August 2012.	F 281		4/8/13

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F 282	Continued From page 44 "agitation."	F 282		4/8/13	
	<p>A Minimum Data Set (MDS) an assessment tool, dated 1/23/13, documented the resident required total dependence for all of his activities of daily living (ADLs).</p> <p>A care plan dated 1/23/13 1/23/12, documented Resident #64 was to have a headrest in place while he sat in his tilt in space wheelchair (TISWC) he liked country western or classical music with headphones, and western movies. Staff was to talk to him about his past and spend one to one time with him especially when he had yelling behaviors. His care plan directed that he was to be put to bed after every meal.</p> <p>The care plan documented, "If unsure what resident is expressing (when yelling) try to satisfy all basic needs of pain, hunger, fatigue, toileting, thirst until resident appears peaceful. May yell out if lonely or wants to listen to music (headphones)."</p> <p>Record review of a pain management flow sheet for February 2013, listed the only non-pharmacological intervention for pain was "Rest." The flow sheet was blank for the entire month of February for any type of pain assessment.</p> <p>A Medication Administration Record (MAR) for February 2013 recorded he received anti-anxiety (Ativan) medication twice during the month on 2/14/13 and 2/26/13. The MAR documented Resident #64 was given Ativan at 10:00 a.m., on 2/26/13 for, "Yelling." A nurse documented at 10:30 a.m., "A little calmer."</p>		<p>Nursing staff has been reeducated by the DNS on implementing care planned interventions as instructed by the care directive.</p> <p>Care Partner program will be initiated to monitor the use of care planned interventions.</p> <p>RCM's will randomly audit residents with yelling behavior weekly for four weeks and monthly for two months to assure care planned interventions are implemented.</p> <p>Copy of audits and Care Partner sheets will be provided to the DNS for review and follow up as necessary. Issue will be reviewed at monthly Performance Improvement Meeting for three months or until resolved to ensure continued compliance.</p>		

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F 282	Continued From page 45	F 282		4/8/13
	<p>A "Staff Pain Observation" sheet last dated 9/24/12, documented Resident #64 had yelling out vocalizations mid-morning and afternoons, he had occasional signs of pain that did not interfere with everyday life (it was not documented how this was determined) and "Rest" was the option for pain or to offer pain _____ as needed. The sheet documented the current (9/24/12) pain management program was effective.</p> <p>On 2/26/13 at 9:50 a.m., Resident #64 was observed sitting in his TISWC in his room. The door to his room was closed. The room blinds were all closed. The resident was facing the TV which was not on. The radio was on a talk radio station. Resident #64 was yelling out approximately every minute. The headrest to his TISWC was positioned back away from the resident's head, not supporting the head while the resident moved his head forward in jerky movements as he yelled.</p> <p>At 9:53 a.m., Staff L was observed to enter Resident #40's room and left within a few minutes. At 10:21 a.m., Resident #64 was in the same position with no head support. The radio was playing rock music. The resident was yelling out.</p> <p>At 10:41 a.m., Resident #64 was in the same condition. The resident could be heard yelling all the way to the nurse's station as well as to the end of the opposite hallway.</p> <p>From 10:50 to 11:50 a.m., Resident #64's room was observed from the hallway while the resident had continuous yelling behavior from his room.</p>			

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F 282	<p>Continued From page 46</p> <p>At 10:50 a.m., three nurses were observed at the nurse's station chatting and laughing. No one responded to Resident #64 who was yelling approximately every minute.</p> <p>At 11:05 a.m., two nurses were observed at a med cart across from the resident's room while he was yelling out. No one entered the resident's room to address his behaviors. For one hour there were at least 23 opportunities of staff passing the resident's room while he yelled out. No one entered his room to check on his condition.</p> <p>At 12:15 p.m., Resident #64 was taken to the main dining room. He was placed at a table by himself facing a wall. Resident #64 yelled out while he sat at the lunch table before his lunch was served at 12:25 p.m. Resident #64 was noted to eat all of his lunch that was fed to him with no yelling behavior while he was fed his meal.</p> <p>At 1:45 p.m., Staff M performed passive range of motion for Resident #64 in his room. The resident yelled out periodically. Staff M stated she did not know if the resident was in pain or not. Staff M stated, "I'm not a nurse. He may be in pain."</p> <p>Staff M was asked about the position of the headrest. Staff M stated the headrest was to "cradle the resident's head" while he sat in the TISWC. Staff M said staff had to take the headrest off every time they used the lift to get him in and out of bed.</p> <p>Staff M said the headrest was not in the correct position and was not supporting the resident's</p>	F 282		4/8/13

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F 282	<p>Continued From page 47</p> <p>head properly on 2/26/13. Staff M said she could get a special tool and fix the headrest but staff was responsible to put it on correctly each time they took it off for transfers.</p> <p>At 1:15 p.m., Resident #64 was observed in the solarium in a small group activity. Resident #64 was yelling and his headrest was not cradling his head. A randomly observed resident yelled loudly in a startled manner, "J---- C-----!" when Resident #64 yelled while he was seated next to her. An activity staff removed Resident #64 from the group.</p> <p>At 2:00 p.m., the resident remained in his room with loud rock music playing on his radio with the blinds closed as had been observed throughout the day.</p> <p>On 2/27/13 at 8:46 a.m., Resident #64 was observed in his room. The resident appeared to be sleeping while he sat in his TISWC. His head was extended back into the headrest and his visual was the ceiling of his room.</p> <p>At 9:04 a.m., the resident was taken to an activity group at the end of the hall. The headrest was not in place to properly cradle his head. The resident yelled out repeatedly while staff attempted to get him to hold a balloon. Staff L removed him from the group and stated she was going to take Resident #64 for a walk. Staff L proceeded to take Resident #64 directly to his room.</p> <p>By 9:11 a.m., Resident #64 was observed back in his room alone. The resident could be heard yelling all the way to the nurse's station. The resident was heard yelling until 9:33 a.m.</p>	F 282		4/8/13

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F 282	<p>Continued From page 48</p> <p>At 9:33 a.m. Staff EE was shaving Resident #64 in his room. Staff EE reported sometimes music calmed down the resident. Staff EE stated she did not know if the current rock music playing in the room was what the resident preferred. When asked if the resident liked headphones, Staff EE said she had never seen him wear headphones, "You would have to ask Activities." Staff EE said she would take Resident #64 to an activity as, "It sometimes calms him down."</p> <p>At 9:40 a.m., Resident #64 was at the end of the hall yelling while in an activity group. His headrest was not positioned to cradle his head. At 10:02 a.m., Resident #64 continued to yell and an activity staff wheeled him to the main dining room. At 10:06 a.m., Staff T wheeled the resident to the activity office/room, took him back out of the office and wheeled him to his room and left him in his room. Resident #64 continued to yell in his room as two activity staff stood outside his door briefly then left the area.</p> <p>At 10:12, 10:15 and 10:30 a.m., Resident #64 was in his wheelchair facing his bed. The headrest was not cradling his head while he continued to yell.</p> <p>At 10:55 a.m., the resident was facing the TV which was not on. There was a pillow behind his head and country western music was playing on his radio.</p> <p>At 11:25 a.m., Resident #64 was observed yelling in his room. The pillow was no longer behind his head. The pillow was on another chair. The headrest was not cradling his head.</p>	F 282		4/8/13
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F 282	Continued From page 49	F 282		4/8/13
	<p>At 1:12 p.m., Staff W and AA were interviewed regarding Resident #64. Staff AA said the resident was "far advanced with dementia." Staff AA said Activities did one to one sessions with him and staff were to play music on his radio to soothe him. Staff AA said the resident liked rock music.</p> <p>At 1:37 p.m., Resident #64 was observed in his bed. The blinds were closed except for approximately 6 inches at the bottom of the window sill. He was yelling continuously.</p> <p>On 2/28/13 at 11:32 a.m., Resident #64 was observed in his TISWC in his room alone. The TV was playing a movie with people screaming and yelling in the program. Resident #64 was yelling continuously. There was a pillow folded over behind his head that was sliding to one side.</p> <p>At 11:48 a.m., Resident #64 was yelling out. The pillow was partially behind his head but had slipped down to the right. The headrest was at shoulder height and not cradling the resident's head.</p> <p>At 1:00 p.m., Staff DD and CC were transferring the resident to his bed. Both staff said the resident only went back to bed after lunch. Staff DD said massaging the resident's arms and hands sometimes helped to calm him down. It was not known how often this might occur as it was usually done by activities.</p> <p>The Hoyer sling was noted to be in the TISWC. Staff DD and CC both stated the sling always remained under the resident in the chair. The</p>			

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F 282	<p>Continued From page 50</p> <p>sling was observed to have sewn ridged areas down the middle where the resident's spinal area would lie on the sling when he was in the chair. The top of the wheelchair seat cushion cover felt lumpy to touch.</p> <p>At 2:47 p.m., Resident #64 was in bed yelling out. The TV was on playing loud infomercials.</p> <p>At 4:36 p.m., Resident #64 was in his TISWC in his room alone. The headrest was approximately 6 inches from the back of his neck and not cradling his head. The TV was on with no sound and the blinds were completely closed.</p> <p>At 4:53 p.m., Staff J said the headrest "Should be closer to his head." Staff J attempted to adjust the headrest and said, "this is not working right." Staff J said if the headrest is not properly positioned (as now) staff should tell the nurse who would then tell the physical therapist to fix the headrest. It was observed Resident #64 would have to extend his head backwards several inches to have it cradle his head.</p> <p>On 3/01/13 at 7:50 a.m., Staff T (an activity staff who had worked with the resident several years) said the activity staff did one to one activities in Resident #64s room including hand lotion, back rubs, and nature sounds CDs. Staff T did not know what type of music the resident preferred. Staff T said she did not know why the blinds would be closed in his room during the day.</p> <p>At 8:00 a.m., Staff T reported she had just checked the resident's care plan and found the resident liked country western music.</p>	F 282		4/8/13
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F 282	<p>Continued From page 51</p> <p>At 1:06 p.m., Staff BB was asked how nursing staff assessed Resident #64 for pain. Staff BB said, "There is no good way to figure out if he is in pain." Staff BB said she thought Resident #64 was blind and could not focus and she wondered if that affected his behavior. Staff BB said she was not sure if the current medications really helped Resident #64's condition or not.</p> <p>On 3/04/13 at 10:25 a.m., Resident #64 was in his TISWC in his room alone. The headrest was placed several inches from the back his head and not cradling his head.</p> <p>At 11:00 a.m., Staff I was interviewed and asked how staff assessed for pain, how staff addressed the yelling behavior, and the proper position of the headrest.</p> <p>Staff I said Resident #64's yelling was, "The norm." Staff I said she did not think the current medication the physician had been trying for several months was effective for the resident. Staff I said, "We try to meet his basic needs when he yells out." Staff I said she would talk to the occupational therapist to address the headrest not being positioned properly in case it was causing him discomfort.</p> <p>Record review of a "Device Assessment" dated 2/21/13, documented, "Per discussion with OT (occupational therapy) will have wheelchair tilt marks from 15-40 degrees for safety and pressure relief for comfort." There was no plan documenting the sling being under the resident in the chair or the proper position of the headrest.</p> <p>Record review of an activity record "Participation</p>	F 282		4/8/13
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F 282	Continued From page 52 Sheet" for the month of February 2013, documented Resident #64 "Actively" participated in sensory stimulation, Happy Hearts, One to One, and pre-Dining activity each day from 2/25/13 through 2/28/13. It could not be determined when each activity took place from the document.	F 282		4/8/13
F 309 SS=G	<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> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record</p>	F 309	<p>F309</p> <p>Resident #100 is no longer in the facility.</p> <p>Resident #101 has had a pain assessment and routine pain medication per physician order.</p>	

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F 309	<p>Continued From page 53</p> <p>review it was determined that the facility failed to provide services to maintain the highest practicable levels for 4 of 29 Sampled Residents (#s 100, 101, 109 & 143) reviewed for care and services of the 38 residents who were included in the Stage 2 review. These failures resulted in harm for Resident #101 due to unmet needs for pain issues and had the potential to place Resident (#s 100, 109 & 143) at risk to not have medical needs met and decline in condition.</p> <p>Findings include:</p> <p>RESIDENT #101 Resident #101 admitted to the facility in 2011 with diagnoses to include [REDACTED] (S05).</p> <p>A Minimum Data Set (MDS) an assessment tool, dated 1/14/13, documented Resident #101 required extensive to total assistance with her activities of daily living. The MDS documented the resident had 6 days of walking sessions during the 7 day observation period.</p> <p>A care plan dated 2011, documented the resident was to participate in a restorative therapy program that included walking 30-50 feet in parallel bars and to stand in the standing frame up to 15 minutes as tolerated, 6 times a week.</p> <p>On 2/26/13 at 3:10 p.m., Resident #101 was observed lying in her bed. She said hello and stated she was resting.</p> <p>A "PRN (as needed) Medication Pain Management Flow Sheet" dated February 2013, documented "Rest" for non-pharmacological</p>	F 309	<p>Resident #109 was reassessed, monitored and physician was contacted to clarify orders related to sustaining a coffee burn.</p> <p>Resident #143 has had a full skin check completed and has been monitored for all non-pressure skin conditions.</p> <p>Dialysis residents with a fistula have the potential to be affected. Dialysis residents with a fistula will have an emergency kit available for possible post dialysis complications and a dialysis information sheet for post dialysis monitoring.</p> <p>Residents with restorative programs have the potential to be affected. Resident restorative programs have been reviewed and revised as needed to reflect any changes in resident condition (including pain) to assure current needs are met.</p>	4/8/13

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F 309	Continued From page 54 interventions to address pain. The flow sheet was blank for the month of February for any pain assessment completed. Record review of a "Restorative Flow Sheet" for February noted the following documentation: 2/02/13- "Resident complained of pain while on standing frame, tried to lower the bars and put table up. Resident still c/o (complained) put resident down. Attempted to walk resident at parallel bars and she stood up with knees [redacted] and wouldn't take a step. LPN (nurse) notified." 2/03/13 - "Seems uncomfortable, without ambulation, difficult to stand at parallel bars." Between 2/06/13 and 2/10/13 documentation noted the resident could not or chose not to participate in the exercise program. 2/15/13- "Complained of pain to knees (during standing exercise)" 2/16/13 - "Resident crying when stood up on standing frame, Resident said, 'Oww' took four steps, knees [redacted]. LPN notified." 2/18/13 - "Complained of pain in in knees. LPN notified." 2/22/13- "Resident complained of pain when up on standing frame. Resident only able to stand but keep knees [redacted]." 2/23/13 & 2/24/13 - "Resident didn't want to ambulate, complained of pain in knees. LPN notified."	F 309	Residents on alert with acute issues have the potential to be affected. RCM's audited residents on alert with acute issues to assure receipt of necessary car and services to attain or maintain the highest practicable, physical and psychosocial well being in accordance with the comprehensive assessment and plan of care. Resident with non-pressure skin issues have the potential to be affected. RCM's have completed a full skin check of residents and have monitored for all non-pressure skin conditions as needed. LN's have been reeducated by the DNS on dialysis policy and procedure and dialysis emergency kits.	4/8/13	

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F 309	Continued From page 55 2/25/13-"Not able to stand at frame, became very agitated." The "Restorative Flow Sheet" had the letters "D/C" (discontinue) written on the sheet on 2/26/13 to stop the ambulation program and the standing frame exercise. Record review of Resident #101's progress notes and Medication Administration Records (MARs) found no assessment for pain regarding the 9 documented entries of pain and 4 refusals during the exercise program for the month of February 2013. No "as needed" pain medication was administered during this time frame. On 2/26/13 at 11:00 a.m., Staff BB said no one had reported Resident #101 having any pain during her rehab exercises. Staff BB said the restorative staff usually talked to her directly if a resident had pain. On 2/26/13 at 11:30 a.m., Staff Z said Resident #101 had not been ambulating in a "long time." Staff Z said Resident #101 could not fully extend her legs to stand. Staff Z said, "We report if residents have pain when they do their exercise program. We had to discontinue (Resident #101's nursing rehab) because she had pain when standing. Her knees are [redacted]." At 11:40 a.m., Staff I said staff had reported to her several times during the month when Resident #101 had pain during standing or trying to walk in her exercise program, "So we discontinued it on the 26th."	F 309	Restorative NAC's were educated by the DNS on the use of the early warning tool (Stop and Watch) to better communicate changes in resident conditions (including pain) to LN's to assure receipt of necessary care and services. LN's have been reeducated by the DNS on the use of the Early Warning Tool and the importance to respond to acute changes in resident condition (including pain). LN's have been reeducated by the DNS on facility policy for assessing, observing and monitoring acute changes in condition. LN's have been reeducated by the DNS on facility policy and procedure for monitoring and documenting identified skin conditions in order to implement timely changes to the treatment plan.	4/8/13	

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F 309	<p>Continued From page 56</p> <p>Staff I acknowledged there was no pain assessment completed and the physician was not notified when the resident complained of pain over the month time frame.</p> <p>At 11:50 a.m., Staff B said she would expect nurses to do an assessment and give pain medication if the resident had an order whenever they complained of pain on an ongoing basis.</p> <p>Resident #101 was not assessed for pain after 18 sessions of rehab therapy during the month of February 2013, when she was made to stand and ambulate while complaining of pain to the point of crying during her exercise sessions.</p> <p>RESIDENT #109 Resident #109 was admitted to the facility in 2011 with multiple medically [REDACTED].</p> <p>A Minimum Data Set (MDS) an assessment tool, dated 1/15/13, documented Resident #109 required extensive assistance with activities of daily living including transfers into and out of her electric wheelchair. The resident was independent with eating after staff assisted her with set up.</p> <p>A care plan dated January 2013, documented Resident #109 had diagnoses to include [REDACTED] and [REDACTED]. Staff was to assist her by giving her a covered cup of coffee with a straw.</p> <p>On 2/28/13 at 12:40 a.m., Resident #109 had covered cup of coffee with a plastic lid and straw on her over bed table. Resident #109 was able to maneuver her electric wheelchair to the nurses' station where staff would hand her a cup of</p>	F 309	<p>Early Warning Tool will be reviewed during the weekly restorative meeting to assure resident needs are being met in a timely manner and are receiving necessary care and services.</p> <p>Nursing progress notes will be reviewed daily to ensure timely physician notification and initiation of orders, this will occur as part of the daily MACC review (Monitoring Acute Condition Change). DNS will document any issues during this review.</p> <p>RCM's will randomly audit Treatment Administration Record's (TAR) weekly for four weeks then monthly for two months to assure documentation and monitoring of identified skin conditions to assure timely implementation of changes to the treatment plan as needed.</p>	4/8/13
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F 309	<p>Continued From page 57</p> <p>coffee. She was not able to get coffee on her own from the coffee dispenser.</p> <p>Resident #109 stated she was given coffee two days before which spilled on her leg causing a burn. Resident #109 said the staff person may not have put the lid on correctly and the coffee burned her upper thigh. Resident #109 said the burn was very painful at the time of the incident. Resident #109 also said she was having trouble with her electric wheelchair control making it hard to move the chair. Resident #109 was known to move about the facility in her electric wheelchair holding a cup of coffee on a daily basis.</p> <p>Record review of a chart note dated 2/26/13 at 8:45 p.m., found Staff N documented Resident #109 had a burn to her upper left thigh that measured 5 cm (centimeters) by 4.6 cm that was "reddish." The note documented the resident said she had spilled coffee on her leg. The note indicated Staff N had notified the physician. Staff N documented he gave the resident a narcotic pain pill for the pain caused by the burn.</p> <p>Staff N documented on a Treatment Administration Record (TAR) dated 2/26/13, "Monitor bruise on left thigh until healed."</p> <p>On 2/28/13 at 1:20 p.m. Staff K, who was on duty and in charge of doing the resident's treatments on 2/27/13, said she had not monitored the burn area on 2/27/13. Staff K said she needed to circle her initials for the treatment on the TAR as "not" monitored on 2/27/13.</p> <p>On 2/28/13 at 1:16 p.m., Resident #109 was observed in her bed. The resident had two burn</p>	F 309	<p>Copy of audits will be provided to the DNS for review and follow up as necessary. Issue will be reviewed at monthly Performance Improvement Meeting for three months or until resolved to ensure continued compliance.</p>	4/8/13

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F 309	<p>Continued From page 58</p> <p>areas measuring 5.0 x 9.0 cm and 4.5 x 2 cm. Both areas were bright red in appearance.</p> <p>On 2/28/13 at 1:16 p.m., Staff G said she first looked at the burn on 2/28/13. Staff G said she could not find any information in the chart regarding what Staff N had done such as a treatment plan for the burn including notifying the physician. Staff G did not know why Staff N had documented the burn as a bruise on the TAR dated 2/26/13. Staff G said Staff D looked at the burn on 2/27/13.</p> <p>At 2:00 p.m., Staff D said she had not looked at Resident #109's burn on 2/27/13. Staff D said she would place Resident #109 on the skin rounds check for the next week (3/07/13).</p> <p>At 3:07 p.m., Staff F who was assigned Resident #109, stated he was told in a morning meeting by the Director of Nursing Services on 2/27/13, that Resident #109 had a burn area on her leg and needed to be assessed that day. Staff F said he never "technically" looked at the resident's burn on 2/27/13. Staff F said, "No one saw it yesterday because she was up all day. I saw it this morning (2/28/13) and it is a burn."</p> <p>At 4:00 p.m., Staff E said Staff N did not did not fill out an incident report on the burn incident as required by the facility policy and he "misquoted" when he documented the burn as a bruise.</p> <p>On 3/04/13, Staff E stated Staff N never talked to the physician on the evening the burn was discovered. Staff E said Staff N had decided (on his own) the burn did not need any type of treatment because it was "after the fact" and</p>	F 309		4/8/13

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F 309	Continued From page 59 there were no blisters observed.	F 309		4/8/13
	<p>On 3/04/13, Staff E said the Director of Nursing Services notified the physician on 3/01/13. The physician could not verify if Staff N left him a voice mail on 2/26/13 regarding the burn.</p> <p>Facility staff failed to re-assess, observe, monitor and report to the physician regarding Resident #109 for over 36 hours after staff was aware she sustained a burn.</p> <p>Refer to F-157</p> <p>RESIDENT #100 Resident #100 admitted to the facility with multiple diagnoses to include [REDACTED] and [REDACTED].</p> <p>Review of the minimum data set (MDS), an assessment tool dated 2/4/13 identified the resident required [REDACTED] treatment (a blood-cleansing procedure). Review of the record revealed the resident received [REDACTED] treatment from an outside [REDACTED] center. Further review did not show evidence Resident #100 received adequate post [REDACTED] monitoring or that the resident had an emergency kit readily available for possible post [REDACTED] complications related to the fistula (a connection between vein and artery for [REDACTED] treatments).</p> <p>Review of the facility's "Dialysis Protocol" dated March 2012 documented, in part, the following:</p> <p>Nursing staff will assess the resident's [REDACTED] site, obtain vitals, perform a mini skin assessment, offer a snack if indicated and keep</p>			

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F 309	Continued From page 60 the resident under observation for the next eight hours Emergency dressing supplies will be kept in each resident's room in case of complications with their [REDACTED] On 2/27/13 at 1:51 p.m., interview with Staff F stated there should be a dialysis flow sheet in the medication administration record (MAR) for the nurses to follow regarding care of the resident's fistula site upon return from the dialysis center. Review of the record did not reveal a completed [REDACTED] flow sheet in the MAR or in the treatment administration record (TAR). Staff F confirmed Resident #100 did not have a completed [REDACTED] flow sheet in the MAR or the TAR for the staff to follow in regards to the care of the [REDACTED] site upon return from the [REDACTED] center. Review of the record revealed a "[REDACTED] Information Sheet" which included communication from the [REDACTED] center and post [REDACTED] assessment (vital signs, weights, mini skin assessment to include assessment of fistula site) to be completed by staff upon the Residents return to the facility. Review of the record revealed Resident #100's post [REDACTED] assessments were incomplete. During the month of February 2013 up until the survey date, there were 11 days the residents weights were not monitored, and six days when the resident's vital signs were not monitored and six days when the [REDACTED] site did not have monitoring upon return from the [REDACTED] center. Staff F confirmed the "[REDACTED] Information Sheets" were incomplete.	F 309		4/0/13	

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F 309	Continued From page 61	F 309		4/8/13
	<p>Review of the record revealed the resident had two sites for [REDACTED] access, a port-a-cath (an implanted venous access device under the skin) and a [REDACTED]. Staff were unaware of which site the [REDACTED] center accessed for treatment, and observations of the room did not reveal there was an emergency kit available for possible post dialysis complications related to the [REDACTED].</p> <p>On 2/27/13 at approximately 1:05 p.m., Staff F reported the resident did not have a [REDACTED], and Staff K reported she assessed the [REDACTED] site for bleeding whenever the resident returned from dialysis.</p> <p>On 2/27/13 at approximately 1:15 p.m., Staff F called the dialysis center to confirm which site the dialysis center accessed for [REDACTED] treatment, and according to Staff F, the dialysis center reported they used the port-a-cath when the fistula did not work.</p> <p>On 2/28/13 at 12:27 p.m., interview with Resident #100 stated the [REDACTED] center accessed both sites, stating when the [REDACTED] does not work the [REDACTED] center will use the port-a-cath for [REDACTED] treatment.</p> <p>On 2/27/13 at approximately 2:00 p.m., staff F reported he would provide the resident with an emergency kit for possible post dialysis complications related the [REDACTED].</p> <p>Failure to consistently monitor Resident #100 for possible post [REDACTED] complications, and failure to provide an emergency kit for possible post [REDACTED] complications related to the [REDACTED] had</p>			

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F 309	Continued From page 62 the potential for staff not to readily identify and act upon possible post- complications/emergencies. RESIDENT #143 An admission nursing assessment dated 2/20/13 documented Resident #143 had a purple area on the left great toe that measured 0.8 cm by 0.2 cm, soft and mushy heels and an open area on the right shin that measured 1.3 cm by 0.6 cm. A "Preliminary Care Plan" dated 2/20/13 identified the resident was at high risk for skin breakdown. The goal documented included "skin doesn't break down." On 3/1/13 at 1:15 p.m. Staff Q and the surveyor reviewed a February 2013 Treatment Flowsheet for Resident #143. The treatment flowsheet documented for staff to conduct a weekly skin check on Tuesdays. A box on the treatment record marked the date one week later on 2/26/13 for staff to conduct the skin check but the box was left blank. The treatment flowsheet also identified for staff to cleanse and dress the area on the right shin daily until resolved. Staff did not document they monitored, cleansed and dressed the area on 2/21/13 and 2/22/13; 2/24/13; 2/27/13 and 2/28/13 after initial discovery on 2/20/13. Another separate area on the treatment flowsheet identified for staff to monitor the purple discoloration on the great toe weekly and marked the date 2/26/13 to be done. The record did not contain evidence staff conducted monitoring on 2/26/13 or thereafter.	F 309		4/8/13

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F 309	Continued From page 63 Staff Q also reviewed two separate "Skin-Grid Forms", one for the open area on the shin and one for the bruise on the [redacted] toe. These forms did not contain evidence staff monitored the purple discoloration on the great toe or the open area on the shin the following week after initial discovery. On 3/1/13 at 1:20 p.m. Staff Q assessed the condition of the Resident #143's heels, shin and [redacted] great toe to ensure they were healing without complication. At this time, Staff Q identified a different red raised area on the [redacted] side of the [redacted] toe and reported it must be new. Failure to monitor two non-pressure skin conditions as identified when needed and conduct a full weekly skin check had the potential for staff to not readily identify if skin conditions or "mushy heels" worsened in order to implement timely changes to the plan of treatment.	F 309		4/8/13	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 323	F323 Resident's # 143 has had a comprehensive review of his [redacted] history, side rail assessment and consent to evaluate the risks and benefits.		

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F 323	<p>Continued From page 64</p> <p>review it was determined that the facility failed to evaluate the effectiveness of bilateral side rails to ensure they were safe for use for 1 of 3 Sampled Residents (#143) reviewed for assistive devices of the 38 sampled residents who were included in the Stage 2 review. This prevented staff from determining if all initial or continued risks associated with use of an assistive device would place the resident at risk for injury and continued risk for use would outweigh its benefit or explore if other alternatives would decrease likelihood of injury. This failure had the potential for the resident to become injured if the resident had a seizure while in bed, if a body part became entrapped between the mattress and the rail or during an attempt to crawl out of the bed with rails raised.</p> <p>Findings include: A Resident Admission Record identified Resident #143 admitted to the facility on [REDACTED] 13 from a hospital. A hospital discharge summary identified the resident was hospitalized in November 2012 with [REDACTED] had a history of a [REDACTED] and diminished mentation. A "Temporary Problem List" dated [REDACTED] /13 documented the resident also had a [REDACTED] [REDACTED] and [REDACTED] [REDACTED]s. Admission physician orders directed staff to administer medication twice a day to treat convulsions. On 2/22/13 at 9:19 a.m. bilateral half rails on both sides of Resident#143's bed were in use while the resident lay in bed. The mattress slid toward the direction of the right side rail. The mattress extended over the edge of the mattress board on the right side and exposed the mattress board beneath the mattress on the left side of the bed. A space that measured approximately four inches wide existed between the mattress and the rail on</p>	F 323	<p>Residents with half side rails have the potential to be affected. Residents with half side rails have had a comprehensive review of their side rail assessments and consents to evaluate the risks and benefits.</p> <p>RCMs and therapy department have been educated by the DNS on the need to have a comprehensive assessment of the resident to evaluate the risks and benefits of half side rails.</p> <p>Residents with referrals for half side rails will be audited by RCMs for 30 days to assure that a comprehensive assessment has been completed and risks and benefits have been explored.</p>	4/9/13

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F 323	<p>Continued From page 65</p> <p>the left side of the bed, large enough to fit a slender arm. Weight records provided by the facility documented on 2/20/13 the resident weighed 135 pounds.</p> <p>On 2/27/13 at 8:18 a.m., when the bed was empty, the mattress centered on the mattress board and minimal space existed between the raised rails and the mattress. When touched lightly, the upper portion of the rails were loose and moved outward approximately two inches creating a space between the rail and the mattress.</p> <p>On 2/27/13 at 2:41 p.m., Resident #143 lay in bed with rails raised. A space wide enough to fit a lower arm between the left rail and the mattress existed when the rail moved outward when touched lightly. Staff H at this time reported the side rails could not be tightened further.</p> <p>A nursing note dated 2/21/13 documented Resident #143 was found lying on the floor on his/her abdomen crawling toward the television to turn it off. "Nursing Care Instructions" identified bilateral half side rails were added to the plan of care on 2/21/13.</p> <p>A nursing note dated the following day on 2/22/13, documented "observed resident trying" to get out of the bed to turn off the television.</p> <p>A "Siderail Evaluation" conducted 2/27/13, six days after rails were added to the bed, contained a checklist of contributing risk factors. The evaluation did not identify the resident could turn over in bed and attempted to crawl out of the bed around the bottom of the side rail on 2/22/13. The evaluation identified Resident #143 did not consistently remember to allow staff to assist with transfers and noted a history of a [REDACTED] disorder. The assessment did not conclude how the latter two factors impacted resident safety.</p>	F 323	<p>Copy of audits will be provided to the DNS for review and follow up as necessary. Issue will be reviewed at monthly Performance Improvement Meeting for three months or until resolved to ensure continued compliance.</p>	4/8/13
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F 323	Continued From page 66 A category on the siderail evaluation form titled "Assessment of risks versus benefits" did not identify what impact the resident's [REDACTED] history or prior attempts at crawling out of bed with side rails in place would have on resident safety or how staff determined continued use of side rails were safe. On 2/27/13 at 3:36 p.m. the surveyor asked Staff I if nursing observed the resident while in bed with side rails raised after they were installed. Staff A reported, nursing did not observe the resident in bed after rails were installed but should have placed the resident on observation for three days following implementation. Staff I reported he/she did not know side rails were loose and a space existed between the rail and mattress when the mattress shifted on the bed board. When asked why the resident needed half side rails, Staff I reported the facility used the type of rail that fit the bedframe. On 3/1/13 at 7:20 a.m., when asked how staff assessed Resident #143 for safe use of rails, Staff I reported nursing and therapy did a collaborative assessment for use of side rails and therapy recommended the rails to increase bed mobility. On 3/1/13 the surveyor requested additional evidence of a safety assessment from the therapy department. A therapy note dated 2/20/13 documented therapy recommended bilateral half side rails to facilitate physical functioning. The therapy note did not contain further assessment to determine if use of side rails were safe for Resident #143 when in actual use. On 3/1/13 at 11:44 a.m. when asked for further details regarding the second incident on 2/22/13, Staff Q reported Resident #143's side rails were in use at the time. Staff Q reported the resident lie	F 323		4/8/13

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F 323	Continued From page 67 on his abdomen sideways across the bed with both legs hanging over the mattress. Staff Q reported the lower half of the resident's body that extended over the mattress was positioned around the end of the right side rail.	F 323		4/8/13
	On 3/1/13 at 12:08 p.m. Staff I reported he/she did not know Resident #143 attempted to crawl out of bed on 2/22/13 (the day after side rails were installed on the bed) and did not know what type of device the resident had in the past. Staff I reported the family was asked and informed the facility today the resident had device since recent onset of a device but did not know what type they were. Some device can cause uncontrollable jerking motion of limbs. In the event this occurred while Resident #143 lay in bed, injury to a body part or entrapment in rail spaces could occur. The record did not contain evidence staff effectively evaluated the use of side rails to identify and addressed the potential for resident injury to occur from the first set of side rails placed on the bed that were loose and created a space between the mattress and rail; the potential for injury if the resident had a device in bed or the potential for injury if the resident attempted to crawl out of bed again with side rails in place, and how rail use benefits outweighed risks of use.			
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels,	F 325		

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F 325	Continued From page 68 unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to revise/or implement the plan of care for 1 of 3 residents. (Resident # 67) reviewed for nutrition. Failure to implement multiple revisions to the care plan to encourage improved nutritional intake resulted in harm due to unplanned avoidable weight loss for this resident. Findings include: Resident #67 was admitted to the facility on [REDACTED] 12 with multiple diagnoses to include [REDACTED] Record review revealed in part, the following weights: 7/23/12, 81 pounds 8/20/12, 79 pounds 9/24/12, 78 pounds 10/15/12, 75 pounds 11/19/12, 73 pounds 12/19/12, 74 pounds 1/23/13, 71 pounds 2/20/13, 70 pounds The Registered Dieticians note dated 6/14/12 documented, the resident had a 6.8% weight loss in 30 days from the admit date of 5/16/12 (which	F 325	F325 Resident #67 had a review of her nutritional care plan and interventions implemented or revised as needed. Residents at risk for significant weight loss have the potential to be affected. DNS completed an audit to identify residents at risk for significant weight loss. Nutritional care plans have been reviewed and interventions implemented or revised as needed. Residents at risk for significant weight loss will be reviewed at weekly Nutrition Committee meeting to assure they maintain acceptable parameters of nutritional status, unless unavoidable. Nursing staff has been reeducated by the DNS on following interventions identified on residents' nutritional care plans.	4/2/13

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F 325	<p>Continued From page 69</p> <p>is "severe" weight loss). The note documented, "diet recently downgraded further to puree with nectar thick liquid related to increased swallowing difficulty, resident also with referral to dentist to eval fit of dentures."</p> <p>The Registered Dietician's note dated 8/2/12, documented the resident had an admission weight of 87 pounds on [REDACTED] 12, and the Resident's weight on 8/1/12 was 79 pounds a 9.2% weight loss in 3 months (which is "severe" weight loss). The dietician's note suggest weight loss may be unavoidable related to [REDACTED].</p> <p>The Registered Dietician's note dated 12/29/12, documented Resident's weight to be 71 pounds on 12/24/12. The not documented, "suspect intake impacted by [REDACTED]"</p> <p>Record review revealed the resident's weight on 2/13/13 was 70 pounds, a 17 pound weight loss which is a severe weight loss of 19.5% since the admission date of [REDACTED]/12.</p> <p>Observations during meal time on 2/26/13 at 8:15 a.m., 2/27/13 between 8:10 a.m. and 8:26 a.m., and 3/1/13 at 8:20 a.m., revealed Resident #67 had multiple bowls of food placed in front of her/him at one time.</p> <p>Review of the record revealed a "Therapy Communication to Nursing" dated 7/2/12, which documented, in part, "Resident requires food items to be in bowls, please put one bowl at a time on the table in front of the resident." Further review of the record did not show evidence that the staff revised the care plan to direct staff to</p>	F 325	<p>RCMs will audit residents at risk for significant weight loss weekly for four weeks, then monthly for two months to assure nutritional interventions are being implemented.</p> <p>Copy of audits will be provided to the DNS for review and follow up as necessary. Issue will be reviewed at monthly Performance Improvement Meeting for three months or until resolved to ensure continued compliance.</p>	4/8/13	

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F 325	<p>Continued From page 70</p> <p>implement the dietician's recommendation to place one bowl of food at a time in front of Resident #67.</p> <p>Staff F stated staff had been in-serviced, although observations revealed the Resident continued to receive multiple bowls of food at one time. Staff F confirmed the care plan and care directive had not been revised to direct staff to place one bowl of food at a time in front of the Resident.</p> <p>On 3/1/13 at 9:00 a.m., interview with Staff F stated the dietary slip should go to the kitchen to inform the kitchen staff of any changes. Staff F confirmed the dietary slip requesting to have one bowl at a time placed in front of Resident #67 had not been sent to the kitchen.</p> <p>On 3/1/13 at 9:20 a.m., interview with the dietary manager (Staff P), confirmed she did not know of the request to have one bowl of food at a time served to Resident #67 for meals.</p> <p>Review of the record revealed a speech therapy note dated 6/18/12 documented, Malnutrition-"not if caregivers providing patient with small portions at a time."</p> <p>FAILURE TO PROVIDE ASSISTANTS Observations during meal on 2/26/13 at 8:15 a.m., 2/27/13 between 8:10 a.m. and 8:26 a.m., and 3/1/13 at 8:20 a.m., revealed Resident #67 sat at the table with other residents and did not receive extensive to total assist from staff with eating. The resident sat at the table with other residents and fed her/himself. Unidentified staff members would approach the resident toward the end of the meal after Resident #67 had stopped</p>	F 325		4/8/13

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F 325	<p>Continued From page 71</p> <p>eating, and would remind her/him to eat her/his meal, and the unidentified staff would then walk away. After the reminder, the resident would take a few more bites of the meal, and would again stop eating. The resident would say, "I want to go to my room," and the staff would take the resident out of the dining room before s/he finished the meal.</p> <p>Review of the facility's care plan documented the resident required the need of 1 person for assist with feeding to encourage adequate intake. The nursing care directive documented the resident required extensive to total assist for eating.</p> <p>On 3/4/13 at 2:48 p.m., interview with Staff X, confirmed that extensive to total assist with meal would be for staff to sit with the resident throughout the meal and assist the resident with eating.</p> <p>DENTURES Resident #67 observed during meal on 2/2/13 at 8:15 a.m., 2/27/13 at 8:10 a.m., and 3-1-13 at 8:20 a.m., to have dentures in while eating.</p> <p>On 3/1/13 at 9:12 a.m., interview with Staff NN reported she brushed Resident #67's dentures and put them in her mouth. Staff NN stated she did not know the Resident was not supposed to have the dentures in because when she last worked on 2/26/13, the Resident had the dentures in.</p> <p>Review of the record revealed a Speech Therapy note dated 5/20/12 documented, "Patient tolerating downgraded diet when wearing properly fitting dentures with adhesive."</p>	F 325		4/8/13

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F 325	Continued From page 72 Review of the record revealed the resident had been seen by "Smile Seattle Dentures" on 6/13/12. According to the dental consult, the condition of Resident #67's dentures were loose or ill fitting, teeth were worn down, bite was off, incorrect, or slides class III bite, and dentures in poor shape. The dental consultant recommended for Resident #67 to have new upper and lower dentures. On 2/28/13 at 4:30 p.m., interview with Staff W stated she spoke with the dentist and the dentist said he never received the referral for dentures from the resident's physician. On 2/28/13 at 4:37 p.m., Staff F and Staff W, stated once a recommendation for dentures is made, the resident care manager (RCM) should submit the "denture/partial appliance request for skilled nursing facility client" to the resident's physician. Staff F confirmed the request for dentures had not been made for this resident. Review of the record revealed the resident continued to have problems eating with ill fitting dentures. Eight months after the request for dentures were made, a nursing note dated 2/19/13 documented, "Staff report resident's upper and lower dentures very loose, and collect food underneath even with use of adhesive. Also resident noted gagging and coughing, refusing to eat when dentures in, but when dentures out, will accept feeding assist better and has increased meal intake, care plan and care directive changed to leave dentures out at this time." Although the care plan and care directive documented to leave the dentures out, staff did not follow the care plan	F 325		4/8/13	

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F 325	Continued From page 73 changes; and staff continued placing dentures in the Resident's mouth.	F 325		4/8/13	
F 328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>The facility had multiple failures that prevented nutritional needs of Resident #67. Failures included, failure to provide 1:1 assistants with meals, failure to follow the plan of care and provide one bowl of food at a time to the Resident during meals, and failure to follow the plan of care and not place dentures to prevent problems with eating. These failures resulted in avoidable severe weight loss of 19.5% between 5/16/12 and 2/20/13.</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure staff provided breathing treatments ordered by the physician for six days for 1 of 1 Sampled Residents (#144) reviewed for</p>	F 328	<p>F328</p> <p>Resident #144 is no longer in the facility.</p> <p>Residents who have respiratory treatment orders have the potential to be affected. RCMs completed an audit of residents with respiratory treatment orders to assure accurate transcription and clarification.</p> <p>Admissions in the past thirty days have been audited by the RCMs to assure accurate transcription and clarification of hospital orders, including respiratory orders.</p>		

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F 328	<p>Continued From page 74</p> <p>██████████ This placed the resident at risk for ██████████ decline.</p> <p>Findings include:</p> <p>On 2/26/13 at 7:30 a.m. Resident #144 sat in bed and Staff Y handed two different inhalers to the resident who self-administered them approximately 10 minutes apart.</p> <p>A Resident Admission Record identified Resident #144 admitted to the facility following hospitalization on ██████████ 13. A hospital History & Physical Exam report dated 2/14/13 documented the resident had a recent history of ██████████. The hospital treated the resident with two antibiotics, steroid medication and breathing treatments.</p> <p>The hospital provided a list of Medication Reconciliation Discharge orders to the facility with checks next to medications the resident received in the hospital and those reported taken at home. Medications included two different inhalers and a breathing treatment provided every four hours while awake.</p> <p>Staff transcribed breathing treatment orders onto facility February 2013 physician orders and a medication flow sheet to be given on an as needed basis and not every four hours while awake as noted on hospital discharge orders.</p> <p>Resident #144's medication records did not contain evidence staff administered breathing treatments every four hours while awake for five days between the time of the resident's admission on ██████████/13 until 12:00 p.m. on 2/27/13.</p>	F 328	<p>Admission Nurses and RCMs were reeducated by DNS on facility policy to have two nurses reviewing hospital and physician orders at time of admission to assure accurate transcription of orders.</p> <p>Medical Records have been reeducated by the DNS on the need to clarify hospital physician orders with the admission nurse to assure accurate transcription.</p> <p>During completion of admission audit by DNS and RCM, hospital physician orders will be reviewed and compared to facility physician orders to assure accurate transcription.</p> <p>Copy of audits will be provided to the DNS for review and follow up as necessary. Issue will be reviewed at monthly Performance Improvement Meeting for three months or until resolved to ensure continued compliance.</p>	4/8/13
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F 328	Continued From page 75 On 3/13 at 11:25 a.m. Staff I reported admission staff checked admission orders then gave checked orders to medical records to type up facility orders and medication records. Staff I also reported facility orders and medication records were then to be reviewed by two nurses for accuracy. Staff I confirmed facility generated physician orders did not match the frequency breathing treatments were ordered in the hospital discharge orders. Staff I clarified the treatment order and reported the physician wanted Resident #144 to receive a breathing treatment routine every four hours while awake and not as needed. Refer to F 281 for failure to accurately transcribe and clarify physician orders.	F 328		4/9/13	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of 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	F 329	F329 Resident #56 had edema measurements completed and results faxed to physician to determine current medication effectiveness.		

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F 329	<p>Continued From page 76</p> <p>as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to adequately or consistently monitor use of all medications prescribed to 1 of 10 Sampled Residents (#s 8 & 56) who were reviewed for medications of the 38 sampled residents who were included in the stage 2 review. Failure to monitor had the potential to place these residents at risk for potential adverse effects from their medications or for staff to not know if or how effective they were.</p> <p>Findings include:</p> <p>RESIDENT #56 [REDACTED] Medication On 2/28/13 at 1:19 p.m. Staff FF observed Resident #56's [REDACTED]. The resident's left and right [REDACTED] were very [REDACTED] and puffy on the top of both [REDACTED]. Staff FF classified the extent of [REDACTED] to the resident's feet as 4+ and 5+ (a tool used to measure recovery when a finger is pressed into an edematous area). The resident's [REDACTED] foot [REDACTED]. The second digit of the left foot had a [REDACTED] that measured approximately 1/4/</p>	F 329	<p>Resident #8 had order obtained for orthostatic blood pressure related to use of [REDACTED] medication.</p> <p>Resident #8 had physician orders clarified to include parameters prior to administration of BP medication.</p> <p>Resident #8's behaviors have been reviewed to assess effectiveness of non-pharmacological interventions and anti-anxiety medication.</p> <p>Residents with an order for edema measurements have the potential to be affected. Residents with an order for edema measurements have been reviewed and results faxed as needed to resident physician for determination of current medication effectiveness and adjustments made as needed.</p>	4/8/13

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F 329	<p>Continued From page 77</p> <p>inch around. Both lower [redacted] had some visible [redacted] and [redacted] when loose upper elastics from tops of both socks were removed.</p> <p>February 2013 Physician Orders identified Resident #56 had diagnoses that included [redacted] [redacted] [redacted] and [redacted]</p> <p>On 8/18/08 the physician directed staff to administer [redacted] medication every morning. Previous orders dated 6/1/08 directed staff to obtain [redacted] measurements on the 20th of every month. On 6/2/10 the physician ordered an additional dose of [redacted] medication given at bedtime.</p> <p>Resident #56's record contained an [redacted] Measurement Flow Sheet" that included actual measurements of the resident's mid arch of right and left feet; right and left foot above the ankle bone and mid-calf measurements on both legs.</p> <p>The resident's record did not contain evidence staff obtained [redacted] measurements during January 2013, February 2013 or for three months between June 2012 and August 2012.</p> <p>On 2/28/13 at 12:35 p.m. Staff K reported there should be an [redacted] monitoring sheet in the treatment book and did not locate one. Staff K reviewed the treatment record for February 2013 that documented the letter "R" inside the box for 2/20/13. Staff K thought it meant the resident refused on that day and stated staff should have approached the resident later.</p> <p>On 2/28/13 at 1:07 p.m. Staff F reported nurses</p>	F 329	<p>Residents with orders for antipsychotic medications have the potential to be affected. Resident physician orders were audited for orthostatic blood pressures related to use of antipsychotic medication and corrected as needed.</p> <p>Residents with orders for blood pressure medication have the potential to be affected. Resident physician orders were audited for parameters prior to administration of blood pressure medication and corrected as needed.</p> <p>Residents with orders for anti-anxiety medication have the potential to be affected. Residents receiving anti-anxiety medication have had their behaviors and documentation reviewed to assess effectiveness of their non-pharmacological interventions and anti-anxiety medication administered.</p>	4/8/13

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F 329	<p>Continued From page 78</p> <p>usually faxed the physician with leg measurements and dose of the medication when leg measurements were out of range. Failure to consistently monitor effects of medication and determine if Resident #56's medication worsened prevented staff from having all information necessary to determine if the physician needed to be notified to determine current medication effectiveness or if adjustments were needed.</p> <p>RESIDENT #8 Antipsychotic Medication On 1/5/13 the physician ordered administration of an antipsychotic medication to be given to Resident #8 at bedtime to treat delirium with antipsychotic. The antipsychotic medication had a potential adverse effect of sudden drop in blood pressure during positional body changes (postural hypotension) that could lead to fainting and consequent fall with injury.</p> <p>The record did not contain evidence staff monitored for the potential side effect of postural hypotension since administration of the anti-psychotic medication began.</p> <p>On 2/27/13 at 3:27 a.m. Staff K reported staff should have taken postural blood pressures daily for three days, then once a week for three weeks, then monthly after the resident started the anti-psychotic medication.</p> <p>On 2/27/13 at 4:20 p.m. Staff F reported the nurse who took the order for the antipsychotic should have initiated postural blood pressure checks. Staff F also reported Resident #8 had a history of falls.</p>	F 329	<p>LN's have been educated by the DNS on the need to completed edema measurements per order and notify physician of results on a monthly basis for determination of medication effectiveness.</p> <p>LN's have been reeducated by the DNS on assuring orthostatic blood pressures are completed monthly on residents receiving antipsychotic medication.</p> <p>LN's have been reeducated by the DNS on the need to obtain parameters prior to the administration of blood pressure medication.</p> <p>LN's will be reeducated by the DNS on the need to document identified behaviors and the effectiveness of non-pharmacological interventions and antipsychotic medications.</p>	4/8/13	

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NAME OF PROVIDER OR SUPPLIER TACOMA NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2102 SOUTH 96TH STREET TACOMA, WA 98444		
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F 329	<p>Continued From page 79</p> <p>Blood Pressure Medication: On 7/17/12 the physician prescribed two different medications for Resident #8 to treat [REDACTED]. The potential side effect of one of the [REDACTED] medications included a low pulse rate or low systolic (upper number) blood pressure reading.</p> <p>Physician orders did not identify specific parameters the physician wanted staff to monitor or what to do if the resident's blood pressure or pulse dropped to certain levels. Medication records did not identify staff took the resident's blood pressure or pulse prior to administration of the blood pressure medication.</p> <p>On 2/27/13 at 3:13 p.m., when asked how staff monitored use of the blood pressure medication, Staff K reported she would do pulse checks. Staff K reviewed Resident #8's medication record and reported staff had not checked pulses before administering the medication.</p> <p>On 2/27/13 at 4:30 p.m. Staff F reported staff just clarified orders with the physician and obtained specific guidelines for pulse and blood pressure the physician wanted monitored.</p> <p>Failure to monitor for side effects of postural hypotension and parameters for blood pressure medication use had the potential for staff to not timely identify adverse effects of these medications and had the potential to increase the resident's risks for falls.</p> <p>[REDACTED]: On 2/5/13 the physician ordered for staff to administer 0.5 mg of [REDACTED]</p>	F 329	<p>RCMs will audit Edema Monitoring sheets monthly for three months to assure edema checks have been completed and results faxed to physicians as needed.</p> <p>RCMs will audit Medication Administration Records (MARS) monthly for three months to assure orthostatic blood pressures have been completed for residents receiving antipsychotic medication.</p> <p>RCMs will audit MARS monthly for three months to assure parameters for blood pressure medications have been obtained.</p> <p>RCMs will audit MARS monthly for three months to assure documentation of the effectiveness of non-pharmacological interventions and [REDACTED] medication.</p>	4/3/13

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F 329	<p>Continued From page 80 medication) to treat increased [REDACTED] every 6 hours as-needed for Resident #8. Staff documented on the reverse side of February 2013's medication records they administered one [REDACTED] pill 21 times between 2/6/13 and 2/25/13. Only 5 out of 21 times staff documented specific [REDACTED] behaviors the resident demonstrated and non-pharmacological interventions attempted prior to administration of medication and its effectiveness.</p> <p>Thirteen out of 21 times staff documented [REDACTED] effective. Seven times staff did not document the results of the medication and once staff documented [REDACTED] ineffective.</p> <p>On 2/26/13 the health care provider ordered to increase the number of pills of [REDACTED] staff could administer from one pill (0.5 mg) to one or two pills (1.0 mg) every 6 hours as needed. On 2/27/13 staff administered the increased frequency of the medication to Resident #8 by administering a second pill every four hours apart. Documentation did not identify what specific [REDACTED] behaviors the resident demonstrated each time they administered the medication or if it was effectiveness for a particular length of time or not effective at all to indicate why they increased the frequency, and thus the dose of the medication.</p> <p>On 2/28/13 at approximately 12:00 p.m., Staff F confirmed the record did not contain consistent documentation of effectiveness of [REDACTED] administered. Staff F reported facility forms were changed and they no longer contained a "grid" staff used in the past to prompt documentation of effectiveness of medication given.</p>	F 329	<p>Copy of audits will be provided to the DNS for review and follow up as necessary. Issue will be reviewed at monthly Performance Improvement Meeting for three months or until resolved to ensure continued compliance.</p>	4/8/13

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F 329	Continued From page 81	F 329		4/3/13
F 371 SS=B	<p>Failure to consistently identify what behaviors Resident #8 demonstrated when given Ativan and consistently monitor effectiveness, had the potential for staff to not know if the medication was effective or if and when the resident required an increased dose or frequency.</p> <p>483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined 2 of 3 Resident Snack Refrigerators (D Hall, and A/B Hall Nursing Station) contained undated and/or unlabeled food. This had the potential to place residents at risk for food borne illness if staff served outdated food to residents.</p> <p>Findings include: A/B HALL NURSING STATION On 3/4/13 beginning 2:15 p.m. the A/B snack refrigerator in the nursing station contained three large 48 ounce containers of mayonnaise based salads that were undated and opened. Staff N,</p>	F 371	<p>F371</p> <p>The snack refrigerators on A/B and D hall have had all undated/unlabeled food items removed.</p> <p>Facility snack refrigerators have the potential to be affected. Resident snack refrigerators have been audited for undated/unlabeled food and items removed as needed.</p> <p>The night shift nurses have been reeducated by the DNS on the need to continue auditing resident snack refrigerators for undated/unlabeled food items.</p>	

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F 371	Continued From page 82 present at the time, reported he did not know who they belonged to. During a meeting on 3/4/13 beginning 4:45 p.m. Staff A and Staff B reported the salads were provided for a staff event last week and should have been placed in the staff break room refrigerator. D HALL REFRIGERATOR ACROSS FROM NURSING STATION On 3/1/13 at 7:54 a.m. the snack refrigerator in the D hall contained a white plastic bag dated 3/1/13 that contained unlabeled Styrofoam containers. The containers did not identify who they belonged to. Staff I, present at this time, confirmed the refrigerator was designated for resident snacks and did not know who the containers belonged to. Staff I also reported the night nurse cleaned snack refrigerators every night. On 3/5/13 at 2:55 p.m. Staff P reported a food item dated 3/1/13 should be removed from the refrigerator by midnight on the date on the container and all containers should be labeled.	F 371	Dietary staff has been educated by the Administrator on providing a daily check of the resident snack refrigerators to assure removal of undated/unlabeled food items. Housekeeping Manager will do random audits weekly for four weeks, then for two months to assure resident snack refrigerators are clear of undated/unlabeled food items. Copy of audits will be provided to the Administrator for review and follow up as necessary. Issue will be reviewed at monthly Performance Improvement Meeting for three months or until resolved to ensure continued compliance.	4/8/13	
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in	F 412	F412 Resident #67 has been referred for dental services and is in the process of receiving new dentures.		

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F 412	<p>Continued From page 83 making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</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 promptly refer 1 of 3 Sampled Residents (Resident #67) for dentures and failed to arrange dental services for 1 of 3 Sampled Residents (Resident #97) reviewed for dental services of the 38 residents who were included in the Stage 2 Review. This failure had the potential to cause harm for Resident #67 and had the potential to place Resident #97 at risk for medical complications.</p> <p>RESIDENT #67 Review of the record revealed the resident had been seen by "Smile Seattle Dentures" on 6/13/12. According to the dental consult, the condition of Resident #67's dentures were loose or ill fitting, teeth were worn down, bite was off, incorrect, or slides class III bite, and dentures in poor shape. The dental consultant recommended for Resident #67 to have new upper and lower dentures. Review of the record revealed the resident continued to have problems eating with ill fitting dentures. Eight months after the request for dentures were made, a nursing note dated 2/19/13 documented, "Staff report resident's upper and lower dentures very loose, and collect food underneath even with use of adhesive. Also resident noted gagging and coughing, refusing to</p>	F 412	<p>Resident #97 has been referred for dental services and treatments as necessary.</p> <p>Residents were audited by Facility Assistant and referred for dental services as needed.</p> <p>RCMs and Social Services have reeducated by the DNS on the use of the dental referral book to assure timely follow up of residents' dental needs.</p> <p>Facility Assistant has been reeducated by the DNS on tracking annual dental exams and monitoring resident refusals to assure timely follow up of residents' dental needs. Social Services will audit dental referral book monthly for three months to assure timely follow up of residents' dental needs.</p>	4/8/13

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F 412	<p>Continued From page 84</p> <p>eat when dentures in, but when dentures out, will accept feeding assist better and has increased meal intake, care plan and care directive changed to leave dentures out at this time." Although the care plan and care directive documented to leave the dentures out, staff did not follow the care plan changes, and staff continued placing dentures in the Resident's mouth.</p> <p>Refer to F325 for further observations, interviews, and record reviews.</p> <p>RESIDENT #97 Refer to F 278 for observations and additional interviews related to the condition of Resident #97's teeth and failure to accurately assess dental conditon.</p> <p>February 2013 Physician Orders identified Resident #97 had diagnoses that included [REDACTED] failure, [REDACTED] and [REDACTED]</p> <p>A nutrition plan of care dated 6/22/11 included an intervention that documented the resident had missing teeth and to monitor for difficulty in chewing and complaint of dental pain. An earlier assessment dated 5/30/12 identified dental concerns for the resident. Current assessments did not identify Resident #97 had poor dentition.</p> <p>Resident #97's medical record did not contain evidence the resident received a dental consult since admission to the facility on [REDACTED]/10.</p> <p>On 3/1/13 at 10:45 a.m. Staff Q reported nursing placed residents on the list to see a dentist and</p>	F 412	<p>Copy of audits will be provided to the DNS for review and follow up as necessary. Issue will be reviewed at monthly Performance Improvement Meeting for three months or until resolved to ensure continued compliance.</p>	4/8/13

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F 412	Continued From page 85 referred as needed. Staff Q also reported the dentist visited the facility monthly.	F 412		4/8/13
	<p>On 3/1/13 at 11:52 a.m. following observation of dental concerns for Resident #97, Staff R reported the facility offered routine dental appointments and had a pink referral book at the nursing station that would identify if staff added a resident to the list to see the dentist.</p> <p>The pink referral book at the nursing station did not indicate staff referred the resident to see a dentist until 2/21/13.</p> <p>On 3/1/13 at 11:56 a.m. Staff I reported during a recent care conference, the resident's guardian just requested a dental consult for the resident. Staff I reviewed the record and did not locate previous dental consults. Following a request, Staff I did not provide additional evidence staff referred the resident to a dentist prior to 2/21/13.</p> <p>Failure to timely refer Resident #97 for a routine dental examination had the potential for the resident to develop difficulty with chewing, chronic dental pain or infection or a gum infection.</p>			
F 518 SS=B	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced	F 518	F518 Staff members X, M, and G have been reeducated by the Maintenance Director on emergency procedures for earthquake, armed intruder and volcanic eruption.	

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F 518	Continued From page 86 by: Based on observation, interview and record review it was determined that the facility failed to ensure 2 of 3 Staff (Staffs M & X) received periodic training in emergency procedures. This had the potential for staff to not readily or appropriately respond during an emergency. Findings include: On 3/1/13 at 9:35 a.m. during facility rounds, Staff H showed the surveyor the location of facility gas lines which had a tool to turn them off. Staff H walked down a flight of stairs outside the building and entered a door to a room that had handles to turn off facility boilers. Staff H reported all staff needed to know how to shut off gas and water lines to the building and pictures were available in the disaster manual. Staff H reported the facility conducted disaster drill in-services twice a year and procedures were reviewed with all new staff. On 3/4/13 at 2:46 p.m. when asked the last time he/she received earthquake training, Staff X reported he/she did not receive training on what to do in an earthquake or what to do if approached by an armed intruder and did not remember receiving training on what to do if a volcano erupted. Staff X reported if gas lines were damaged, maintenance would turn them off and did not know where they were located. On 3/4/13 at approximately 2:45 p.m., when asked what she would do if an earthquake started, the floor was rolling and ceiling tiles were falling, Staff M reported he/she would start to	F 518	Staff members X, M, and G have been reeducated on the location of the gas and water shut off valves. Facility staff has the potential to be affected. Facility staff has been reeducated on emergency procedures for earthquake, armed intruder and volcanic eruption. Facility staff has also been reeducated on the location of the gas and water shut off valves. Maintenance Director will continue to do emergency preparedness training with facility staff. A copy of signed in service sheets will be provided to the Administrator for review and follow up as necessary to assure completeness of training. Issue will be reviewed at monthly Performance Improvement Meeting for three months or until resolved to ensure continued compliance.	4/8/13	

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F 518	<p>Continued From page 87</p> <p>evacuate residents next door or take them into the parking lot. Staff M reported he/she did not need direction from administration to begin evacuation but just needed to do it. Another unidentified staff member present during the interview agreed with Staff M. Staff M knew the location of the gas line shut off and reported main water lines were located at the top of the ceiling in the nursing station and needed to be turned off if damaged. Staff M did not identify the need to turn water off at the location of facility boilers.</p> <p>The facility policy and procedure for Earthquake identified caregivers should not go outdoors and to turn off damaged utilities (gas, water and electricity).</p> <p>On 3/4/13 at 2:55 p.m. recently hired Staff G reported she had not yet received training on emergency procedures and pointed to the location of the emergency manual in one of the nursing stations and reported, in an emergency there would not be "time to read it."</p> <p>On 3/4/13 at 2:10 p.m. during an interview with Staff A and Staff H, both reported the facility recently conducted mock earthquake drill and bomb threat exercises.</p> <p>Staff H reported, staff should first protect themselves during an earthquake and position themselves against a wall in the hallway. After the earthquake, staff should check on residents; check for injuries; and check for gas leaks and water leaks. Staff A and Staff B would direct evacuation if needed.</p> <p>On 3/4/13 at 3:40 p.m. Staff H provided training</p>	F 518		4/8/13	

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F 518	<p>Continued From page 88</p> <p>sign in sheets for the most recent earthquake training. The list did not contain the names of Staff X or Staff M to indicate they attended. Staff H reported disaster trainings were mandatory and conducted one per shift. If staff did not attend the training safety committee members were supposed to review the information with them. Staff H did not know how safety committee members knew which staff did not attend mandatory training and who they needed to review the information with.</p> <p>The facility conducted disaster training and did not have evidence all staff attended and knew what to do during an earthquake that included the need to initially protect themselves from injury, location of gas and/or water lines to the building and responsibility for all staff to turn them off in a disaster or protocol for evacuation.</p>	F 518		4/8/13