

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

PRINTED: 02/18/2014
FORM APPROVED
OMB NO. 0938-0391

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 02/05/2014
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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 1/21/14, 1/22/14, 1/23/14, 1/24/14, 1/27/14, 1/28/14, 1/29/14, 1/30/14, 1/31/14, 2/3/14, 2/4/14 and 2/5/14. A sample of 53 residents was selected from a census of 98. The sample included 49 current residents and the records of 4 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>Marilyn Edwards, RN, MN Ruth Futch RN, BSN, MBA Sandra Mayes, RN, BSN Gilda Warden, EdD, RN-BC</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging and Long-Term Support Administration Residential Care Services, District 3, Unit B PO Box 45819, MS: N27-24 Olympia, WA 98504-5819</p> <p>Telephone: 253-983-3800 Fax: 253-589-7240</p> <p><i>D. Longen-Shims</i> Residential Care Services</p>	F 000	<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>	3/10/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 2/28/14
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</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 care was provided in a manner that maintained or enhanced resident dignity and respect during transport via shower chair, between resident rooms on D Wing and the shower room on A Wing, for 2 of 5 Sampled Residents (#s 1 & 36) reviewed for dignity. This failure placed residents at risk for psychological harm, including embarrassment and diminished self-esteem.</p> <p>Findings include:</p> <p>Observations during survey between 1/21/14 through 1/24/14 and 1/27/14 through 1/31/14 revealed shower staff did not use the shower on the D Wing to shower residents.</p> <p>Residents who resided in the D Wing in the back nursing unit were transported by staff to the front nursing unit to shower in the A Wing. Residents on the D Wing had to travel the length or partial length of the D Wing hallway, turn right down a center hall that connected to the front nursing unit, pass by the main entrance to the dining room, pass through the open area connected to the front lobby and then turn left onto the A Wing. The A Wing shower was approximately one half</p>	F 241	<p>F241</p> <p>Resident #1 and #36 remain in the facility.</p> <p>Resident #1 is transported fully clothed to the shower room.</p> <p>Resident #36 is transported on shower chair covered for privacy with "bucket" beneath.</p> <p>Residents will be fully clothed while being transported to and from the shower room as able.</p> <p>If resident is unable to be dressed and/or undressed in the shower room, they will be partially clothed and completely covered.</p> <p>Shower aides were in-serviced relating to techniques to promote dignity for residents during transportation from their room to the shower room</p> <p>DNS and or designee will monitor compliance through direct observation and resident interviews.</p>	3/10/14

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F 241	<p>Continued From page 2</p> <p>to two thirds of the way down the length of the A Wing hallway.</p> <p>On 1/28/14 at 12:49 p.m., Staff L reported the D Wing shower room had been closed for six months since a bottle got stuck down the drain. Staff L said, since the D Wing shower became inoperable, residents on D Wing were taken to the shower room on A Wing for showers.</p> <p>On 1/30/14 at 12:22 p.m., Staff M reported all residents on the D Wing except for two had to be transported in a shower chair to shower. Residents in shower chairs were undressed in their rooms and wrapped up in three shower blankets while being pushed in a shower chair from the D Wing to the A Wing.</p> <p>On 2/4/14 at 12:10 p.m. Staff A provided information regarding the distance from the D Wing to the A Wing. The length of the center hallway that connected the front nursing unit to the rear nursing unit measured 120 feet. Residents on the D Wing had to travel approximately up to 370 feet to reach the shower located on the A Wing.</p> <p>Refer to F 253 for additional observations and interviews regarding maintenance concerns related to the inoperability of the shower room on D Wing.</p> <p>RESIDENT #36 Resident #36 was admitted to the facility on [REDACTED] with diagnoses to include [REDACTED]. The resident was non-ambulatory and dependent on facility staff for extensive assistance with activities of daily living.</p>	F 241	<p>Progress and trends of audits will be reported during monthly QAPI meeting.</p> <p>DNS or designee will be responsible to ensure correction</p>	3/10/14

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F 241	<p>Continued From page 3</p> <p>On 1/28/14 at 12:49 p.m., during an interview with Staff L and Staff M, Staff L expressed concern about dignity for residents being transported via shower chair the long distance between D Wing and A Wing, stating, "To me, it's a dignity issue."</p> <p>Staff M agreed that dignity was a concern. Staff M said Resident #36 lived on D Wing and received showers on A Wing. Staff M said Resident #36 reported feeling embarrassed when transported via shower chair through the facility covered only by a bath blanket.</p> <p>On 1/29/14 at 10:58 a.m., when asked if he/she had any concerns related to showers, Resident #36 said, "Yeah, the one down here has been broke for months and they know it and they're not doing anything about it. They have to haul me down the hall past all the people in the hall. I'm naked, only covered by a sheet."</p> <p>Resident #36 further stated, "I don't like it. Would you? Naked with only a sheet. There's a hole in the chair, nothing covering my bottom. All the way from my room to the shower and back. I don't like it."</p> <p>RESIDENT #1 Resident #1 was initially admitted to the facility on [REDACTED] with a history of [REDACTED]. The resident was alert, oriented and was incontinent of bowel and bladder.</p> <p>On 1/27/14 at 9:56 a.m., Staff M was observed transporting Resident #1 from the shower room on A Wing to the resident's room near the far end of D Wing.</p> <p>Resident #1 was seated on a wheeled shower</p>	F 241		3/10/14

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F 241	<p>Continued From page 4</p> <p>chair which had an open seat with no bucket underneath. Resident #1 was wrapped in a flannel bath blanket so that his/her buttocks and genital area were concealed from view while open to air from below.</p> <p>After Resident #1 and Staff M arrived at the resident's room, Staff M and Staff ZZ prepared to use the Hoyer lift to transfer Resident #1 to the bed. The resident repeatedly said "Hurry." As Resident #1 was being lifted from the shower chair, he/she was incontinent of a large bowel movement on the floor.</p> <p>On 1/27/14 at 10:15 a.m., when asked how he/she felt about being transported via shower chair between D Wing and A Wing, Resident #1 said it was difficult because it hurt his/her bottom to sit in the shower chair that long. The resident did not specifically verbalize feelings about the episode of incontinence.</p> <p>On 1/30/14 at 12:30 p.m., Staff M stated he/she did not think Resident #1 was aware of the episode of incontinence on 1/27/14 because the resident was focused on his/her painful bottom and was anxious to get back to bed. Staff M said if Resident #1 had been aware of having a bowel movement on the floor the resident would have been embarrassed.</p> <p>Staff M said none of the shower chairs had buckets. Staff M said he/she told Staff J there were no buckets for the shower chairs approximately one or two months ago when another resident had a bowel movement in the hall in front of the dining room as Staff M was transporting the resident from D Wing to the shower room on A Wing.</p>	F 241		3/10/14

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F 241	Continued From page 5 The facility failed to ensure care was provided in a manner that maintained or enhanced resident dignity and respect during transport via shower chair between resident rooms on D Wing and the shower room on A Wing. This failure placed residents at risk for psychological harm, including embarrassment and diminished self-esteem.	F 241		3/10/14
F 253 SS=F	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain a safe, clean and comfortable environment for residents, staff and visitors in 4 of 4 Shower Rooms; 1 of 4 Resident Care Wings (D Wing) and in the laundry and chapel bathroom. This placed residents at risk for decreased quality of life and compromised dignity. Findings include: Tacoma Nursing & Rehabilitation Center consists of four Wings, A, B, C & D Wings. The A & B Wing in the front of the facility is considered one nursing unit and the C & D Wing located in the back of the facility also is one nursing unit. The front and the back units are connected by a hall that connects perpendicular to the front and back	F 253	F253 A Wing shower room: Drains have covers. Gray/brown colored debris has been removed. Tile has been repaired. Grout has been repaired. Gray rubber strip has been removed. Calking was repaired.	

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F 253	<p>Continued From page 6 units in the building.</p> <p>A WING SHOWER ROOM On 1/28/14 at 12:49 p.m. Staff M reported there were two shower stalls in the A Wing shower but only one stall worked. Staff M reported "crud" backed up from the drain and residents commented they felt uncomfortable in the shower.</p> <p>On 1/28/14 beginning 2:30 p.m. during environmental rounds, the shower room on the A Wing had two shower stalls divided by a tiled wall whose height extended approximately 2/3 of the way from the floor to the ceiling. Floor and wall shower tiles were a light off white color. The right shower stall contained a white PVC piped receptacle that contained a plastic bag with linen and did not have a faucet to turn on water or a shower spray head. The left side of the shower stall used to shower residents. The following concerns were identified during observations:</p> <ul style="list-style-type: none"> -Both shower floor drains that measured approximately 4 inches wide were not covered. Drain pipes that extended below the level of the shower floor were visible. -Dried gray/brown colored debris surrounded the drain on the right shower stall. Debris encircled the floor drain covering an area that measured approximately three feet wide. - The left shower stall on the right back corner had an area of missing tile that measured approximately four inches wide and a half an inch across on the right side. The area beneath missing tiles were discolored black. 	F 253	<p>Tiles have been cleaned.</p> <p>Fan covers have been cleaned.</p> <p>Grout has been cleaned and/or repaired.</p> <p>Door has been sanded and stained.</p> <p>Nursing and housekeeping staff have been provided keys to shower rooms.</p> <p>During any major jetting process shower rooms will be monitored and not used during the time of jetting.</p> <p>B Wing shower room:</p> <p>Tile has been replaced.</p> <p>Fans have been dusted.</p> <p>Ceiling fan has been repaired.</p> <p>Grout has been cleaned and/or repaired.</p> <p>Shower curtain has been replaced.</p> <p>The walls have been repainted.</p>	3/10/14

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F 253	Continued From page 7 - The left base of the shower stall divider had an area of missing grout that measured approximately seven inches by one inch exposing black discoloration beneath. -A long gray rubber strip approximately two inches high covered the transition between the floor linoleum tile in the bathroom and the porcelain tiled left shower stall. The transition strip had a long crack down the center that measured approximately two feet long. -Caulking between the edge of the gray transition strip and bathroom floor contained black discoloration. -Off white colored linoleum tiles had scattered areas of dark discoloration throughout which gave a dirty appearance to the floor. -A vent fan cover on the shower room wall and an off white vent cover in the ceiling had a visible coating of dust. -Shower wall tiles measured approximately 4 inches square with white colored grout between them. Tiles in the left shower stall contained black discolored areas within the grout over an extensive area along the back and right side of the shower stall. -The blue wall in the shower had missing areas of paint that exposed white beneath. -The exterior hall side of the shower room door had three long streaks of lighter beige covering that felt slightly rough to the touch. The streaks were lighter in color than the rest of the stained door surface.	F 253	Floor has been cleaned. C wing shower room: Grout has been cleaned and/or repaired. D Wing shower room: Drain has been cleared. Floor has been cleaned. A wing utility room red biohazard bin has been emptied. Resident #30 has been provided new shoes. Resident #86, room has been cleaned. Resident #12 room has been cleaned. Resident #79, bathroom has been cleaned. No smoking is allowed outside the dining area. Resident #54 bathroom floor has been cleaned.	3/10/14	

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F 253	<p>Continued From page 8</p> <p>On 1/28/14 at 2:17 p.m. housekeeping Staff MM reported he/she did not have access to the locked shower room on the A Wing and did not have a key. Staff MM showed the surveyor a picture of a map on the hall that identified areas assigned to be cleaned. Staff MM reported he/she had not been informed to clean shower rooms daily and had not cleaned them during the past two weeks.</p> <p>On 1/29/14 at 11:06 a.m. Resident #95 reported using the shower room twice a week and it needed to be cleaned.</p> <p>On 1/29/14 at 12:04 p.m. Staff LL reported housekeeping duties included cleaning the shower about once a week. Staff used a special cleaner on the grout but the black came back right away.</p> <p>During environmental rounds on 1/29/14 beginning 2:22 p.m. Staff Q looked at the gray/brown debris that encircled the shower drain on the right shower stall and reported the discoloration was "gray water" and not sewage. Staff Q reported the material around the drain occurred from "jetting" (flushing) facility plumbing last week. Staff Q observed drain covers were missing and reported no one had reported it to maintenance.</p> <p>On 1/30/14 at 12:21 p.m. to 12:37 p.m. Staff M reported residents from the D Wing (back unit) used the shower in the A Wing (front unit). Staff M reported both shower stalls had backed up and showed the problem to Staff Q who stated it was housekeeping's job to clean it up. Staff M reported housekeeping staff said it wasn't their job to clean it up. Staff M reported he/she cleaned</p>	F 253	<p>Resident #109 room has been cleaned.</p> <p>Resident # 30 bathroom has been cleaned.</p> <p>Resident #12, #53, #76 #82, #86 bathroom has been cleaned.</p> <p>Resident #79 bathroom has been cleaned.</p> <p>Resident #79 laminate has been repaired.</p> <p>Resident #15, #21, #100, #110 rooms at base coving has been cleaned.</p> <p>Molding around the main dining room doors has been replaced.</p> <p>Restorative room floor has been cleaned.</p> <p>Activity room floor has been cleaned.</p> <p>The front of the C/D nursing station floor has been cleaned.</p>	3/10/14

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F 253	<p>Continued From page 9</p> <p>the back up from the left shower stall residents used so they could shower.</p> <p>Staff M also reported when residents saw the back-up from the drains they said "that's gross." Staff M also reported one resident refused to shower during the past week and a half until it was fixed.</p> <p>On 1/30/14 at 1:25 p.m. when asked what he/she thought of the A Wing shower, Resident #20 reported "they had the sewage stuff come out of the drain."</p> <p>On 1/30/14 at 1:40 p.m. Resident #128 reported he/she did not like to use the A Wing shower because it was "backing up" and told Staff M it was "icky." Resident #128 also reported the bottom of both shower stalls had filled up with unclear water and he/she had not showered since a week ago last Monday (1/20/14).</p> <p>A plumbing company invoice requested on 1/30/14 identified the plumbing company performed jetter maintenance on 1/24/14.</p> <p>On 2/7/14 at 2:08 p.m. Collateral Contact (CC)YY reported jetting flushes water using high pressure toward main outside lines and would not cause a back up of water to go up shower drains. CC YY also reported most of the time back up in shower drains was caused when soap choked drain lines and then usually a cable could be used to get the flow going again.</p> <p>B WING SHOWER ROOM</p> <p>On 1/28/14 at 1:24 p.m. Staff K reported the B Wing shower had yellow liquid bubbling from the floor since October (2013). When asked how</p>	F 253	<p>The chapel bathroom has been painted.</p> <p>Laundry room has been dusted.</p> <p>Ceiling vents have been cleaned.</p> <p>The personal clothing room has been cleaned and closet rod with dress was removed.</p> <p>Area with blue box has been cleaned and box removed.</p> <p>Laundry staff was provided with new brooms.</p> <p>C/D Medication Room:</p> <p>Lights have been repaired.</p> <p>Lamps have been removed.</p> <p>Ceiling fixture in bathroom has been repaired.</p> <p>Sink, mirror and countertops have been cleaned.</p> <p>Paper towel dispenser and soap dispenser have been filled.</p>	3/10/14

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F 253	<p>Continued From page 10</p> <p>many residents were showered in the B Wing shower, Staff K reported 52 residents from both the A Wing and the B Wing were showered weekly in the B Wing shower. Some residents were showered once a week and some more frequently. Staff K also reported since residents from the D Wing (back of building) used the shower in the A Wing (front of the building), residents from the A Wing showered in the B Wing.</p> <p>On 1/28/14 at 1:38 p.m. the B Wing shower room smelled very musty upon entering. The ceiling fan to vent the room did not function. Staff K reported the fan had not worked since October (2013) and two other fans were used all the time to keep the steam down. Staff K also reported when doing showers he/she needed to "take a break because the steam is so great" and eyeglasses steamed up when using the shower.</p> <p>During this observation, the following concerns were identified in the shower room:</p> <ul style="list-style-type: none"> - Two operational portable fans were placed at the farther end of the shower. When turned off, one of the fans on a tall beige cabinet had visible strings of dust covering the outer spokes. - One of the floor ceramic tiles located inside the front door located outside of the showering area had multiple cracks in it. One crack measured approximately five inches long and another two inches long. - Shower area walls consisted of white tiles that measured approximately six inches square separated with white grout. An area of tiles that measured approximately four and a half feet high 	F 253	<p>Floor has been cleaned.</p> <p>Sharps container has been emptied.</p> <p>Drawers and cupboards have been provided handles.</p> <p>Garbage can lid was removed.</p> <p>Housekeeping has updated task lists and scheduled cleaning of floors, shower rooms, med rooms, utility rooms and common areas in facility.</p> <p>Biohazard bins have been placed on a housekeeping task list for scheduled emptying.</p> <p>Bathroom floors that need completely redone will be scheduled for repair pending construction review.</p> <p>Shower Rooms will be audited weekly as part of the preventative maintenance rounds to assure repairs are completed and area is clean.</p>	3/10/14	

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F 253	<p>Continued From page 11</p> <p>by three and a half feet wide contained blackened discoloration in the grout.</p> <p>-A light colored shower curtain had rust colored stains across half of the bottom of the curtain and another streak about half way up the height of the curtain.</p> <p>-The painted blue wall across from the door had multiple lighter colored streaks that traveled horizontally down the wall. Streaks covered an area that measured approximately three and a half feet tall and wide.</p> <p>-Threshold flooring beneath the entry shower room door off the B Wing was discolored and darker compared to the rest of the flooring. The area of discoloration measured approximately four feet wide.</p> <p>On 1/29/14 during observations beginning 1:38 p.m., Staff K reported water bubbles rose from a tile in the floor and pointed to the cracked tile on the floor located outside the shower area. Staff K also reported he/she reported the problem before and most recently informed Staff P last Friday (1/24/14).</p> <p>Staff K also reported a former resident commented about mold in the shower and refused to take a shower in the room.</p> <p>On 1/29/14 at 10:14 a.m. Staff A placed their body weight on the area surrounding the tile and caused bubbles and water to come out of the grout that surrounded the cracked tile. Staff A reported grout around the cracked tile had holes and thought the problem originated from beneath the tile. Staff A reported he had not been made</p>	F 253	<p>Shower Aides will be reeducated on using the maintenance logs to report needed repairs.</p> <p>Resident Rooms will be randomly audited weekly as part of the preventative maintenance rounds to assure repairs are completed and area is clean.</p> <p>Staff will be reeducated on using the maintenance logs to report needed repairs.</p> <p>Laundry room will be audited monthly as part of the preventative maintenance rounds to assure repairs are completed and area is clean.</p> <p>Laundry Staff will be reeducated on using the maintenance logs to report needed repairs.</p> <p>Common areas will be audited monthly as part of the preventative maintenance rounds to assure repairs are completed and area is clean.</p> <p>Progress and trends of audits will be reported during monthly QAPI meeting.</p>	3/10/14	

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F 253	<p>Continued From page 12 aware of the problem before.</p> <p>Staff A also reported blackened grout in the shower area had been an "ongoing issue" and "we are still working it out." Staff A reported staff tried all sorts of chemicals and it didn't get clean.</p> <p>On 1/29/14 at 12:50 p.m. when asked what the black discoloration on tile grout was, Staff P reported it was mildew. Staff P reported staff tried bleach and soap scum remover which did not work.</p> <p>On 1/30/14 at 1:20 p.m. Housekeeping Staff NN reported when new housekeeping services started in October (2013) staff did not know who cleaned the showers - the aides or the housekeepers. Shower aides disinfected showers between residents and asked housekeeping for supplies. Staff NN reported Staff P thought shower aides cleaned the showers and reported at the end of the day evening housekeepers gave showers a thorough cleaning.</p> <p>Staff NN also reported "as of today" the duty to routinely clean showers had just been added to housekeeping routines.</p> <p>Later on 2/4/14 at 5:56 p.m. evening Staff WW reported he/she did not clean showers as part of evening cleaning duties.</p> <p>C WING SHOWER On 1/29/14 at 3:12 p.m. Staff A, Staff Q and the surveyor looked at the C Wing shower room. The room had a musty odor noticeable upon opening the door. Black discoloration on white tile grout was located throughout the back and sides of the shower area. Staff A reported the black did not</p>	F 253	Administrator or designee will be responsible to ensure correction	3/10/14

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F 253	<p>Continued From page 13 come out even with bleach and the grout will probably have to be removed.</p> <p>On 1/30/14 at 12:21 p.m. to 12:37 p.m. Staff M reported the C Wing shower had mold.</p> <p>D WING SHOWER ROOM Observations during survey between 1/21/14 through 1/24/14 and 1/27/14 through 1/31/14 shower staff did not use the shower on the D Wing to shower residents. Resident census during those times ranged between 27 to 28 residents on the D Wing. Shower records provided on 2/4/14 indicated only 1 resident preferred a bed bath and remaining residents showered.</p> <p>On 1/28/14 at 12:49 p.m. Staff L reported the D Wing shower room had been closed for six months since a bottle got stuck down the drain. Staff L reported concerns residents got cold being transported to the other side of the building to get showered.</p> <p>On 1/28/14 at 1:24 p.m. Staff K reported since the D Wing shower did not work, residents from the D Wing showered in the A Wing.</p> <p>On 1/29/14 at 2:22 p.m. Staff Q opened the locked D Wing shower door and reported a container of shaving cream became lodged in the curve joint of the drain pipe where pipes met. The facility could not extract it and a plumbing company could not snake or drain it. Repair would require the floor to be jack hammered and would shut the drain pipes down in the building. Staff Q also reported the repairs would take days or weeks and would affect quality of life for residents.</p>	F 253		3/10/14

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F 253	<p>Continued From page 14</p> <p>On 1/30/14 at 1:25 p.m. Resident #20 reported he/she used to shower in the D Wing shower room and stated it was "brown and yucky" and "I wish they would fix it." Resident #20 also reported the shower had been broken a long time.</p> <p>The D Wing shower room at this time had a dried crusted brown film of debris that surrounded the shower floor drain. The area of film covered an area of approximately a three foot wide circle.</p> <p>Staff A provided a copy of a plumbing invoice requested on 1/30/14. The invoice date indicated plumbing services were provided on 5/22/13.</p> <p>On 2/4/14 at 8:34 a.m. Staff P provided a copy of training records for housekeeping staff. Records identified all but one staff member received training on 1/9/14 or 1/10/14, more than two months after new housekeeping service provider began.</p> <p>ODORS A WING UTILITY ROOM On 1/22/14 at 1:51 p.m. the hallway near the A Wing Utility Room had a very strong and unpleasant odor that traveled noticeably further down the hall.</p> <p>On 1/30/14 beginning 2:25 p.m. staff opened the A Wing utility room door to leave the room. As the door opened an extremely unpleasant odor wafted out of the room into the hallway. The surveyor asked Staff QQ to assist with a tour of the utility room at this time.</p> <p>Upon entry into the room the unpleasant odor became stronger. Staff QQ did not know the cause of the odor.</p>	F 253		3/10/14

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F 253	<p>Continued From page 15</p> <p>Directly inside the room door a red biohazard barrel had an unclosed, partially opened, raised lid. Staff QQ opened the lid and three sharps containers lay on top of multiple filled plastic bags. One of the bags was red in color to indicate biohazard waste.</p> <p>Staff XX then entered the room and also did not know the source of the odor or how long the barrel had been full. Staff XX reported the barrel should be emptied when full and housekeeping emptied it weekly.</p> <p>Staff G reported nursing staff disposed of sharps containers (used needles) into the red barrel and did not know who emptied barrels when full.</p> <p>On 1/30/14 at 3:30 p.m. Staff A entered the utility room and stated "oh my" in response to the odor. Staff H, summoned by staff, opened the door and stated " this stinks bad. This is bad, shouldn't be this bad."</p> <p>A short while later Staff H reported the odor came from a red biohazard bag that leaked vomited blood. Staff H also reported he/she looked in the bin and observed blood leaking from a biohazard bag which must have been from a resident who had gastrointestinal bleeding.</p> <p>A progress note dated 1/19/14, 12 days earlier, documented a staff member noted a large amount of bright red emesis (vomit) in a garbage can in Resident #92's room.</p> <p>A daily work routine that listed job duties for housekeepers provided by Staff P on 2/14/14 at 1:40 p.m., indicated to clean the utility room daily</p>	F 253		3/10/14

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F 253	<p>Continued From page 16 at 7:45 a.m. The work schedule did not specifically indicate when and how often to empty biohazard barrels.</p> <p>ADDITIONAL ODORS</p> <p>RESIDENT #30 A nursing progress note dated 1/10/14 documented Resident #30 commented how his/her shoe smelled and continued to wear the same shoes without socks.</p> <p>On 1/22/14 at 1:51 p.m. an unpleasant odor was present in the hall outside Resident #30's room.</p> <p>On 1/23/14 at 2:40 p.m. there was an unpleasant odor present in Resident #30's room. The resident sat in a wheelchair near the doorway at this time and reported his/her footwear smelled because drainage from a foot infection saturated the footwear. The resident removed the footwear and the surveyor validated the odor from the footwear was the same odor present in the hall and in the room.</p> <p>SHOWER ROOM ODORS During environmental rounds on 1/28/14 at 1:24 p.m. and at 1:38 p.m. and on 1/29/14 at 2:30 p.m. the shower on the B Wing had a musty odor.</p> <p>On 1/29/14 at 2:30 p.m. when interviewed regarding the B Wing shower room, Staff Q reported the tile needed to be cleaned and fixing the exhaust system should help with the odor.</p> <p>On 1/28/14 at 12:49 Staff L reported he/she reported the C Wing shower room smelled liked mold to housekeeping a month ago. On 1/29/14 at 3:12 p.m. the surveyor noted the C Wing</p>	F 253		3/10/14	

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F 253	<p>Continued From page 17 shower had a strong musty odor.</p> <p>RESIDENT ROOM ODORS During rounds on 2/4/14 beginning 6:00 p.m. to 6:20 p.m. the bathrooms in Resident #12 and Resident #86 's rooms had an unpleasant strong musty smell. Staff Q present confirmed the musty odor and reported it smelled like mildew or mold and did not know the cause.</p> <p>Resident #79's bathroom had a stale unpleasant odor that permeated the room.</p> <p>DINING ROOM ODORS On 1/21/14 at 12:37 p.m. an unidentified resident smoked on the patio just outside the Main Dining Room during the noon meal. The smell of smoke wafted throughout the dining room. The resident who smoked was clearly visible to dining room staff through the window. A sign on the exit door stated no smoking in that area during dining and activities. Staff did not intervene. An automatic door opened and closed slowly, allowing smoke to waft into dining room.</p> <p>RESIDENT BATHROOMS A WING, B WING & C WING Resident bathrooms contained linoleum that curved up the bottom edges of walls approximately four inches (coving).</p> <p>On 1/21/14 at 1:03 p.m. Resident #54's bathroom had gray and brown stains surrounding the periphery of the room at the base of the coving.</p> <p>On 1/22/14 at 8:03 a.m. and 2/4/14 at 6:00 p.m. Resident # 109 ' s bathroom had a strong urine smell.</p>	F 253		3/10/14	

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F 253	<p>Continued From page 18</p> <p>On 1/22/14 at 1:32 p.m. Resident #30's bathroom floor had yellowed/gray stains around the periphery of the room at the base of the coving. Staff NN looked at the discoloration and reported the discoloration occurred after the facility stripped and waxed floors in this area. Staff NN thought housekeeping Swiffer mops used pushed dirt against the baseboard of the bathrooms. Staff NN reported Resident #30's bathroom needed to be scrubbed with stripper and scraped since dirt collects along the coving.</p> <p>On 2/4/14 beginning 6:00 p.m. to 6:20 p.m. bathrooms in rooms of Residents (#s 12, 53, 76, 82 & 86) had edges of coving around the periphery of bathroom floors that were discolored yellow and/or a gray/brown in color. Additional areas of discoloration were evident scattered throughout the linoleum flooring and under the toilets.</p> <p>During the same observation Resident #79's bathroom had a stale unpleasant odor. The edges along a laminate counter in Resident #53's bathroom were missing. Staff Q reported it needed to be redone.</p> <p>Bathrooms in rooms of Residents (#s 15, 21, 100 & 110) had yellow and gray discoloration along the periphery of the room at the base of the coving.</p> <p>HOUSEKEEPING/MAINTENANCE COMMON AREAS The following were identified during environmental rounds on 1/21/14 at 4:05 p.m.:</p> <p>-The inside doorframes in the Main Dining Room were missing molding on the lower base of the</p>	F 253		3/10/14

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F 253	<p>Continued From page 19</p> <p>molding above the floor. One piece was missing on the doorway adjacent to the middle hall and the other piece was missing on the doorway adjacent to the C Wing. Each missing piece of molding exposed unfinished carpentry that measured approximately six inches tall and four inches wide.</p> <p>- The Restorative Room at the end of the D Wing contained numerous scuff marks and areas of gray discoloration that appeared considerably lighter than the off white tile beneath.</p> <p>- The Activity Room on the D Wing contained areas of gray discoloration throughout that appeared considerably lighter than the off white tile beneath.</p> <p>- The front of the C/D Wing Nursing Station had blackened material coated along the base of coving adjacent to tile flooring that extended the approximately eight feet across the width of the station.</p> <p>- Throughout all days of survey 1/21/14 through 1/31/14 wallpaper border placed in the center of walls in the chapel bathroom extended around three of the walls. The wallpaper border was considerably torn throughout the entire distance.</p> <p>LAUNDRY ROOM On 1/29/14 during observations in the laundry rooms beginning at 12:11 p.m. through 1:48 p.m. washing machines were coated with a visible layer of dust. Pipes behind the washers also contained visible dust.</p> <p>Two tall ceiling vents in the ceiling above the dryers were coated with a thick visible coating of</p>	F 253		3/10/14

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F 253	<p>Continued From page 20</p> <p>dust.</p> <p>The floor of the room laundry staff used to process and hang resident clean personal clothes had multiple brown crusted spots. A closet rod that hung a resident 's black dress dragged on the floor near the area of the spots.</p> <p>In the far right corner of the room a blue plastic box with grooves contained multiple boxes of laundry products. The grooves on the surface of the box and surrounding floor were scattered with white laundry powder. A space approximately eight inches wide between the box and the wall contained additional laundry powder and large visible clumps of dust.</p> <p>When asked who cleaned the laundry room. Staff TT reported "laundry people sweep the laundry " with dry brooms. Staff TT pointed to two brooms that lay against the doorframe of the room staff used to process personal clothing. The ends of two brooms that rested on the floor were heavily coated with large, thick clumps of dust.</p> <p>MEDICATION ROOM ON C/D WING</p> <p>A single medication room, measuring approximately 12 x 12 feet, served C and D Wings and was located through a door at the back of the C/D Wing nursing station.</p> <p>To the left of the entrance inside the medication room was a door leading to a small room containing only a toilet. To the right of the entrance was a sink/cabinet vanity approximately 3 feet wide. There was open shelving along the wall to the left. At the back of the room was a row of cupboards above a countertop with drawers</p>	F 253		3/10/14	

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F 253	<p>Continued From page 21</p> <p>below. There was a 4 x 3 foot window in the far left corner, half concealed by an opaque curtain. A large medication cart was in the center of the room in which overstock of resident medications was stored.</p> <p>1) Lighting concerns in the C/D Medication Room</p> <p>On 1/29/14 at 3:53 p.m., during observation with Staff OO, the medication room was dimly lighted.</p> <p>The medication room had housings for four florescent light fixtures: two on the ceiling which were approximately three feet long, one over the sink approximately 18 inches long, and one under the cupboards over the counter approximately 14 inches long.</p> <p>There was only one functional light fixture in the medication room: the ceiling fixture on the left. The other ceiling fixture, and the fixtures over the counter and sink, had no shades/covers or light bulbs. A tall table lamp with no shade was sitting on the counter and was not plugged in. Staff OO said he/she had never seen the lamp turned on or plugged in.</p> <p>Another tall table lamp with no shade was sitting on the toilet room floor; the lamp was turned on and the door left open, which Staff OO said was to help illuminate the medication room. The ceiling light fixture in the toilet room had no cover or light bulb and the fixture base was loose, hanging by wires.</p> <p>Staff OO said the nonfunctional lights in the medication room and toilet room had been inoperable for several months. Staff OO said, in order to see well enough to perform tasks such</p>	F 253		3/10/14

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F 253	<p>Continued From page 22</p> <p>as drawing up medications in a syringe or pouring liquids into a cup, he/she had to hold materials up close to the one functional ceiling light.</p> <p>A small refrigerator sitting on the counter, stocked with insulin for residents on C and D wings, did not have a functional interior lamp. Staff OO agreed that insulin needed to be kept within a recommended temperature range and it was difficult to read the thermometer in the refrigerator without a flashlight or taking the thermometer out of the refrigerator.</p> <p>On 1/30/14 at 11:20 a.m., Staff Q said he/she received a work order for the nonfunctional lights in the C/D Wing medication room about four months ago but he/she had not figured out how to fix the lights without cutting power to the C/D wings.</p> <p>2) Other maintenance and housekeeping concerns in the C/D medication room</p> <p>A deep cleaning schedule provided by the facility on 1/24/14 at 2:30 p.m. indicated the medication room on the C/D Wing was scheduled for cleaning on the 25th day of the month.</p> <p>On 1/29/14 at 3:53 p.m., during observation with Staff OO, four days after the cleaning schedule indicated the medication room was to have been cleaned, the following concerns were identified:</p> <p>-The white porcelain sink basin was covered with light brown residue. Much of the vanity countertop surrounding the sink was covered in light white/gray residue. Approximately 2/3 of the mirror above the sink was covered with white splatter marks.</p>	F 253		3/10/14

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F 253	<p>Continued From page 23</p> <ul style="list-style-type: none"> -The paper towel dispenser was empty; a stack of paper towels was lying on the vanity countertop approximately three inches from the sink. -The soap dispenser mounted over the sink vanity was empty. The soap dispenser refill cartridge was sitting on the vanity countertop. -Shades/covers for the nonfunctional light fixtures were sitting on an open shelf covered in dust and soot. Two fluorescent light bulbs were on the floor, leaning against the wall. -Large areas of the floor were covered with dark gray/black residue, dust and small amounts of debris. In the corner under the window there was a large amount of debris covered with dust. -The countertop under the cupboards was covered with light gray/white residue. -The sharps container for discarding used syringes and needles, attached to the medication cart, was filled approximately two inches over the fill limit line. -Drawers: Eight supply drawers had no handles and three drawer handles were hanging loose, attached by one screw. Cupboards: Six supply cupboards had missing handles with sharp ends of screws protruding outward. <p>On 1/30/14 at 10:56 a.m., during observation of the C/D medication room with Staff B, all observations identified on 1/29/14 were unchanged.</p>	F 253		3/10/14

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F 253	<p>Continued From page 24</p> <p>In addition, there was a plastic garbage can lid sitting on the countertop, approximately 18 inches wide with an opening in the center. The garbage lid was completely covered with black residue and old food. Staff B said, "This shouldn't be here. It's going straight into the trash."</p> <p>On 1/30/14 at 1:58 p.m., when asked who cleaned the C/D Wing medication rooms, Staff OO reported only licensed nursing had keys to enter the medication room. Staff OO also reported housekeeping staff had never asked to have Staff OO open the medication room door. Staff OO reported if garbage in the medication room needed to be picked up "I pick it up" but did not clean with a disinfectant. Staff OO had not seen anyone disinfect and scrub floors in the medication room.</p> <p>On 2/4/14 at 5:57 p.m., Staff P said housekeeping staff did not clean medication rooms because they did not have access to those areas. Staff P said he/she was unaware of a written policy to verify housekeeping staff were not responsible for cleaning medication rooms.</p> <p>"Daily Work Routine" forms that listed job duties for light housekeepers identified for housekeeping staff to clean nursing stations. The list did not specifically include the need to clean the medication room adjacent in the nursing station.</p> <p>During the status meeting on 2/5/14 beginning 10:40 a.m., Staff A confirmed nursing staff needed to be present in order for housekeeping to enter and clean medication rooms. Staff A and Staff B could not identify when nursing staff</p>	F 253		3/10/14
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F 253	Continued From page 25 coordinated a specific time to allow housekeeping an opportunity to clean medication rooms. The facility failed to adequately supervise housekeeping staff to ensure all areas of the facility were cleaned according to schedule and as needed.	F 253		3/10/14
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 interview and record review the facility failed to develop a comprehensive care plan to	F 279	F279 Resident #59 remains in the facility and plan of care has been updated re: dental care Residents identified with dental concerns have been reviewed and care plans updated as appropriate Staff completing comprehensive assessments have been re-educated to the communication and referral process	

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F 279	<p>Continued From page 26</p> <p>meet the dental needs identified in the comprehensive assessment for 1 of 3 Sampled Residents (# 59) reviewed for dental needs of the 53 residents who were included in the Stage 2 review. This failure placed the resident at potential risk for not attaining the highest practicable physical, mental and psychosocial well-being identified in the comprehensive assessment.</p> <p>Findings include:</p> <p>Refer to F411 for dental services</p> <p>The Minimum Data Set (MDS) Admission Assessment dated [REDACTED] listed active diagnosis for Resident #59 to include [REDACTED]</p> <p>[REDACTED] The facility's list of diagnosis included [REDACTED]</p> <p>A review of the Care Area Assessment (CAA) Summary listed dental care as a triggered area. The CAA detail report dated 12/11/13 identified the dental care triggers were indicated related to obvious or likely cavity or broken teeth; Mouth or facial pain, discomfort, or difficulty with chewing.</p> <p>A review of the Social Services Assessment/History/Discharge Plan observation report completed by Staff R on 12/9/13 reports in the section Assistive Devices: Dentures - the resident "Needs Exam". During an interview on 1/27/14 at 10:28 a.m., Staff R reported she/he was unaware of Resident #59 dental issues.</p> <p>The CAA Detail report Analysis of Findings summary reports the "Resident with poor dentition, missing broken carious teeth which</p>	F 279	<p>Random audits of comprehensive assessments will be completed to ensure on-going compliance.</p> <p>Progress and trends of audits will be reported during monthly QAPI meeting.</p> <p>DNS or designee will be responsible to ensure correction</p>	3/10/14

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F 279	<p>Continued From page 27</p> <p>resident states has dental pain when she/he chews. Resident requires set up and encouraged to perform adequate oral care. Resident is at risk for declines in dental status. Staff to monitor declines and treat issues. Staff to monitor appropriateness of diet texture, provide encouragement and assist with oral care."</p> <p>1/24/14 at 11:11 a.m., Resident #59 stated when asked that she/he wanted to see the dentist, but so far there was no mention of this. The resident said "I have a mechanical soft diet and it gives me problems eating with three teeth on top and three on the bottom to chew on. They are getting weak and will fall out soon." She/he confirmed had not visited dentist since admission to facility and did not know if was on a list for a visit and would like to be seen.</p> <p>During an interview on 1/27/14 at 10:28 a.m., Staff R and Staff S reported that nursing keep the dentist referral book. If need was emergent would get the resident in as soon as can. On admit nurses do head to toes evaluation. When doing the initial referral assessment, if mentioned, staff will put resident's name in referral book or tell the nurses who will do it.</p> <p>Resident # 59 was not care planned for dental care though identified as a one of several problem in the CAA summary.</p> <p>The facility failed to develop a care plan to address the dental needs identified for Resident #59 in the comprehensive assessment. This failure had the potential risk for avoidable decline in dental status for the resident.</p>	F 279		3/19/14

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F 309 SS=E	<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 review it was determined the facility failed to provide necessary care and services to attain or maintain the highest practicable level of physical, mental and psychosocial well-being when the facility: failed to consistently and thoroughly reassess, monitor and/or effectively manage pain for 2 of 3 current Sampled Residents (#s 41 & 15) reviewed for pain; failed to consistently obtain communication from the [REDACTED] center and monitor status after treatment for 1 of 1 Sampled Residents (#123) reviewed for [REDACTED] failed to consistently monitor and document bruising or assess for proper fitting footwear for 2 of 3 Sampled Residents (#s 30 & 156) reviewed for non-pressure skin issues of the 53 residents who were included in the Stage 2 review.</p> <p>These failures placed Resident #41 and Resident #15 at risk for insufficiently managed pain; had the potential for staff to not know if complications occurred during [REDACTED] or timely identify and obtain treatment for complications that could develop following treatment for Resident #123; placed Resident #30 at risk for delayed healing or re-injury and placed Resident #156 at risk for</p>	F 309	<p>F309</p> <p>Residents #41 and #15 have been re-evaluated for optimal pain management</p> <p>Resident #123 has pre- and post [REDACTED] monitoring in place</p> <p>Resident #30 was provided with (and encouraged to wear) clean, proper fitting footwear;</p> <p>Resident #156 no longer resides at the facility</p> <p>Pain: Residents have been reviewed for pain management and adjustments made as appropriate</p> <p>[REDACTED] Residents on [REDACTED] have been reviewed to ensure pre and post [REDACTED] monitoring is in place</p> <p>Shoes: Resident's footwear has been audited to ensure that residents have clean, functional footwear</p>	3/10/14

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F 309	<p>Continued From page 29 potential complications from use a blood thinning medication.</p> <p>Findings include:</p> <p>RESIDENT #41 - PAIN Resident #41 was originally admitted to the facility on [REDACTED] with diagnoses to include [REDACTED]. The resident was re-admitted on [REDACTED] and [REDACTED].</p> <p>The Pain Interview Admission Follow Up (PIFU), dated 5/31/13, documented Resident #41 had "very severe, horrible" pain on the entire right side, shoulder to foot. The PIFU indicated a plan to assess the resident's pain every shift and notify the physician if an increase in pain was noted.</p> <p>The annual Minimum Data Set (MDS), a required assessment tool, dated 10/16/13, documented Resident #41 was alert and oriented. The resident had difficulty communicating but was usually able to make him/herself understood if prompted or given time. The resident was non-ambulatory and dependent on facility staff for extensive assistance with activities of daily living. The MDS identified Resident #41's pain frequency as "almost constantly" and indicated the pain made it hard for the resident to sleep.</p> <p>Medications Flowsheets (MARs), from 5/23/13 through 1/31/14, documented Resident #41 received two routinely scheduled medications for pain: 1) [REDACTED] milligrams (mg) extended release tablet 3 times daily, and 2) ibuprofen 400 mg twice daily. The resident did not have an "as needed" (PRN) pain medication for</p>	F 309	<p>Bruising: Residents with bruises are assessed when bruise is identified are monitored weekly until resolved</p> <p>Nursing staff will be re-educated on pain management, [REDACTED] monitoring, monitoring for use of proper footwear and monitoring of bruises.</p> <p>Random audits of pain management, [REDACTED] monitoring, monitoring for use of proper footwear and monitoring of bruises will be completed to ensure on-going compliance.</p> <p>Progress and trends of audits will be reported during monthly QAPI meeting.</p> <p>DNS or designee will be responsible to ensure correction</p>	3/10/14

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F 309	<p>Continued From page 30 breakthrough pain between scheduled doses.</p> <p>Resident #41's care plan for pain, dated 11/6/12, indicated the resident had pain on "right side of body with neuropathy." The care plan instructed staff to administer pain medication and monitor and record effectiveness. The care plan further instructed staff to monitor and record any complaints of pain, including location, frequency, effect on function, intensity, alleviating factors, aggravating factors and assess for effects of pain on the resident's quality of life, including sleep disturbances.</p> <p>Resident #41's care plan for pain did not identify a referral to a pain clinic or a neurologist.</p> <p>No documentation was located reflecting regular ongoing monitoring of Resident #41's pain, or assessment of the effectiveness of [REDACTED] and ibuprofen, as indicated in the resident's care plan.</p> <p>The Pain Interview Admission Follow Up (PIFU), dated 5/31/13, was the most recent pain assessment located in Resident #41's medical record. The only documentation located which addressed Resident #41's pain after 5/31/13 was located in occasional random progress notes stating the resident did not complain of pain.</p> <p>During an interview on 1/22/14 at 9:59 a.m., Resident #41 was observed lying in bed. The resident was grimacing slightly and had difficulty with word-finding. Resident #41 stated he/she had constant pain from head to toe on the right side of his/her body and said the pain pills helped but the resident did not get them when he/she needed them.</p>	F 309		3/10/14	

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F 309	<p>Continued From page 31</p> <p>On 1/27/14 at 10:59, Staff AAA said Resident #41's right foot was very sensitive to touch and the resident often reported pain.</p> <p>On 1/28/14 at 12:23 p.m., Staff BBB said Resident #41 frequently had pain on the right side of his/her body. Staff BBB said the resident often put on the call light to ask for pain medication and the aides would inform nursing staff, who would bring the pain medication if it was time. Staff BBB said staff had to be very careful when handling the right side of the resident's body because "it hurts so bad. [Resident #41] says 'Ouch', be careful."</p> <p>On 1/28/14 at 1:30 p.m., Staff PP said Resident #41 received [REDACTED] routinely, three times daily and did not ask for anything in between scheduled doses. Staff PP said the resident often asked for the routine dose, saying "I'm hurting." Staff PP said he/she did not ask the resident about pain location or intensity and did not monitor or assess for effectiveness of the [REDACTED]. Staff PP said, "If [Resident #41] was getting PRN medication, we would document for effectiveness, but with routine pain medications we just give them."</p> <p>On 1/28/14 at 2:46 p.m., Staff B said staff did not need to assess and document Resident #41's pain because the resident only received scheduled pain medication, not PRN.</p> <p>Staff B said he/she was unaware of any current concerns related to pain for Resident #41. Staff B said, "In the absence of ongoing pain, I think a quarterly note should be adequate," even for a resident routinely receiving a narcotic pain</p>	F 309		3/10/14

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F 309	<p>Continued From page 32 medication such as [REDACTED]</p> <p>When asked about the resident's care plan to monitor pain and report effectiveness of pain medication, Staff B said pain was not identified as a concern at Resident #41's most recent quarterly evaluation and the resident's care plan was out of date. Staff B said if pain was an issue it would have been identified through review of progress notes and the Stop and Watch communication tool in which staff forward issues of concern to Resident Care Managers.</p> <p>On 1/28/14 at 4:12 p.m., Staff B said he/she had just spoken with Resident #41 and the resident reported he/she had ongoing right-sided pain which, just before receiving scheduled doses of [REDACTED] was 9/10 on a 1-10 pain scale. The resident told Staff B that after getting the medication the pain was 5-6/10. The resident said he/she would be happy with a pain level of 3/10. Staff B provided a copy of the progress note documenting what the resident reported.</p> <p>On 1/29/14 at 12:05 p.m., Staff K stated Resident #41 reported pain "all the time" and said the resident was "very vocal" about the pain. Staff K said the resident's right foot was especially sensitive and staff had to be very gentle when putting shoes on that foot.</p> <p>On 1/29/14 at 12:19 p.m., Staff D said he/she had not been informed of pain issues with Resident #41. When asked how Resident #41 should be assessed for pain, Staff K said a pain assessment should include asking the resident if he/she had pain, and identifying pain location, intensity and frequency. Staff D said that, because Resident #41 had difficulty</p>	F 309		3/10/14

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F 309	<p>Continued From page 33 communicating, a chart with facial expressions should be used to assess intensity of pain.</p> <p>Staff D indicated the last pain assessment conducted for Resident #41 was the Pain Interview Admission Follow Up, dated [REDACTED].</p> <p>The facility failed to consistently monitor and effectively manage pain for Resident #41, placing the resident at risk for inadequately managed pain.</p> <p>RESIDENT #15 - PAIN An admission record identified Resident #15 admitted on [REDACTED] from a hospital. Diagnoses listed included [REDACTED]</p> <p>A physician visit form dated 11/18/13 documented Resident #15 had [REDACTED] and to continue pain control.</p> <p>January 2013 Medications Flowsheet (MAR) identified the physician ordered the following pain medications at different dates:</p> <p>11/29/08: Acetaminophen as needed for general muscle aches; pain and headaches. 8/30/12: Analgesic balm top cream twice a day for left ankle pain. 4/20/13: [REDACTED] (narcotic) 5-325 mg every evening "for pain" 6/21/13: Lidoderm patch (medicated topical local anesthetic patch) to both knees in the morning for pain.</p> <p>A plan of care originally dated 10/28/11 identified a long term goal that "pain will be managed at a</p>	F 309		3/10/14
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F 309	<p>Continued From page 34</p> <p>level" the resident "found acceptable." The care plan contained multiple interventions dated 7/3/13 that included:</p> <ul style="list-style-type: none"> - Adjust pain management interventions as needed if ineffective; - Assist to reposition as needed - Medications as ordered - document effectiveness of prescribed medication; - Monitor and record any complaints or non-verbal symptoms of pain and - Observe and report indications of increased discomfort. <p>A communication care plan dated 12/31/12 identified the resident spoke a foreign language as primary language. Interventions dated 7/1/13 documented the resident did not understand most English, some simple words and phrases understood, used gestures.</p> <p>Care plan interventions also identified a family member who visited almost daily could help translate and additional language services could be used to interpret. Interventions identified staff should anticipate the resident's needs and wants; observe for and use gestures and utilize a book as needed that translates the resident's foreign language into English.</p> <p>On 1/22/14 at 10:02 a.m., during an interview utilizing interpreter services, Resident #15 sat in a wheelchair and pointed to her lower back when asked if she had pain. The resident told the interpreter she had "burning" pain and rated it at level 5 on a 1 -10 pain scale.</p> <p>On 1/23/14 at 12:50 a.m. Staff GGG reported Resident #15 could not "yes" or "no" when asked if in pain. Staff GGG also reported the resident</p>	F 309		3/10/14

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F 309	<p>Continued From page 35</p> <p>would point to her stomach if staff said "heartburn" and then nodded head.</p> <p>On 1/23/14 at 1:46 p.m. Staff PP reported the resident had shoulder pain and got a lidocaine patch and also a muscle rub. When asked how staff knew the Resident #15 had pain, Staff PP reported the resident would grimace and point to the pain. When asked how staff knew if pain medication was effective Staff PP reported the resident would no longer grimace when pointing to his/her shoulder.</p> <p>Staff PP could not describe characteristics of the resident's pain such as type of pain or intensity or why the resident received the narcotic pain medication. Staff PP looked at the medication record which identified the narcotic medication was given for "pain" and did not describe type or location of pain.</p> <p>On 1/24/14 at 1:00 p.m. the surveyor could not locate a current re-assessment of Resident #15's pain to obtain further information.</p> <p>On 1/24/14 at 1:18 p.m. Staff B reported staff completed pain assessments and the assessments were "not what I would like" as far as tools to work with. Staff B reported the computer system did not allow nursing to conduct an off cycle assessment for pain. Initial pain assessments were conducted in a questionnaire and everything else went into progress notes. The surveyor requested evidence of a current re-assessment of pain for Resident #15 without success.</p> <p>On 1/27/14 at 9:55 a.m. Staff D reported nursing staff completed admission pain assessments in</p>	F 309		3/10/14	

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F 309	<p>Continued From page 36</p> <p>the computer for initial reported pain. When asked to describe sources of Resident #15's pain, Staff D reported a quarterly assessment in the computer system had a section to reassess for pain and could not locate it. Staff D reported he/she would look for a previous assessment form used before implementation of the computer system.</p> <p>A "Staff Pain Observations" pain screening tool dated 8/7/13 through 8/9/13 provided by the facility documented the resident showed signs of pain that worsened with transfers. The re-assessment indicated pain was due to arthritis and prior joint replacement and the resident desired relief of pain at less than level 3.</p> <p>Required Quarterly Minimum Data Set Assessments (MDS) were conducted 8/30/13 and 11/22/13. Both assessments identified the resident reported pain during the five day assessment period. Both MDS's indicated a pain interview should be conducted. When asked if the resident had the presence of pain, both MDS's indicated "unable to answer." Neither of the pain assessments identified the resident's intensity or frequency of pain or impact on daily function. The record did not contain evidence nursing staff used assistance of an interpreter or language book with foreign phrases to assist with obtaining more detailed information from the resident regarding pain concerns.</p> <p>Staff documented on the January 2014 medication record they administered acetaminophen to Resident #15 on 1/5/14 and 1/21/14. The record did not identify why staff administered it or the results of the medication.</p>	F 309		3/10/14	

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F 309	<p>Continued From page 37</p> <p>Staff did not complete a quarterly re-assessment of Resident #15's pain during the most recent quarter or consistently monitor results of pain medication given on an as needed basis. The resident's record did not contain a current re-assessment that clarified characteristics of pain or what type of pain the scheduled narcotic medication was prescribed to treat. The record did not contain evidence staff clarified current pain triggers; which non-pharmacological interventions were attempted and if successful or if resident goals for pain control as identified in the care plan were met.</p> <p>Failure to thoroughly re-assess the pain management program for Resident #15 had the potential to place this resident at risk for unmanaged pain or less than optimal pain control.</p> <p>RESIDENT #123 - [REDACTED] On [REDACTED] Resident #123 admitted to the facility following hospitalization. Diagnosis identified on an admission record included [REDACTED]</p> <p>A physician note dated 1/21/14 documented the resident had [REDACTED] while hospitalized and transferred to the facility for rehabilitation.</p> <p>On 1/24/14 at 10:36 a.m. Resident #123 sat in bed and reported staff provided a sack lunch when going to appointments outside the facility. The resident showed the surveyor a black bag attached to a walker taken on appointments also.</p> <p>On 1/24/14 at 11:10 a.m. the resident prepared to</p>	F 309		3/10/14	

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Continued From page 38
leave the facility by shuttle for an outside treatment appointment.

A care plan with start date 10/21/13 included approaches to complete [REDACTED] assessments and notify the physician as needed; assess the [REDACTED] access site daily to ensure functioning; if bleeding from the [REDACTED] occurred apply pressure and notify 911; monitor the access site daily for redness, swelling, edema, warmth to touch and/or complaints of pain and report to the physician.

[REDACTED] Flowsheets contained instructions for licensed staff to monitor Resident #123 for all areas identified in the care plan except to complete [REDACTED] assessments.

On 1/24/14 at 10:12 a.m. Staff G reported Resident #123 went to [REDACTED] three times a week and returned to the facility during the evening shift. Staff G also reported staff sent a form to [REDACTED] with the resident and the resident returned the form to the facility. Staff G reported licensed nursing (LN) staff should monitor and check the resident's vital signs (blood pressure, pulse and respirations) and [REDACTED] access site upon return and should complete the information on the bottom of the form.

On 1/28/14 at 9:47 a.m. Staff PP also reported nurses should complete the assessment on the bottom portion of the [REDACTED] form as soon as the resident returned to assess the resident's condition.

On 1/28/14 at 3:41 p.m. Staff OO reported when Resident #123 returned from the [REDACTED] center he/she looked for the [REDACTED] form the center

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F 309	<p>Continued From page 39</p> <p>returned and filled out monitoring information on the bottom of the form. Staff OO also reported if the center did not send the form back he/she did not contact them to request it.</p> <p>On 1/30/14 at 12:02 Staff D reported sometimes the [REDACTED] center did not return [REDACTED] sheets and staff could call and ask for a report.</p> <p>The [REDACTED] Center Communication Form" contained a space on the top for [REDACTED] staff to document new orders; weights before and after treatment, medications given; treatments and lab work, the condition of the access site and dietary changes. The form did not specifically have a space to document the resident's vital signs during or after [REDACTED]. The lower portion of the form contained a space for facility staff to document a "Post [REDACTED] Nursing Assessment" when the resident returned that included the resident's condition and vital signs and note of signs and symptoms of [REDACTED] complication.</p> <p>[REDACTED] Communication Forms in Resident #123's medical record dated 11/1/13 through 1/31/14 contained 12 out of 25 returned forms staff did not document [REDACTED] monitoring results. Seven forms were missing according to dates the resident was scheduled to receive [REDACTED]</p> <p>Resident #123's medical record did not contain evidence licensed staff consistently obtained communication from the [REDACTED] center, reviewed the information or monitored the resident's medical status following return to the facility after treatment as identified in the care plan. This had the potential for staff to not know if complications occurred during [REDACTED] or timely identification of [REDACTED]</p>	F 309		3/10/14

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F 309	<p>Continued From page 40 possible complications developed following treatment.</p> <p>RESIDENT #30 - SHOE ASSESSMENT On 1/22/14 at 7:49 a.m. Resident #30 lay in bed in room with feet uncovered. An open wound on the second toe on the right foot drained clear fluid.</p> <p>On 1/23/14 at 2:40 p.m. Resident #30 sat in a wheelchair and wore a pair of black sneakers. Both legs were wrapped in a dressing. The resident's foot did not fully fit into the sneaker and the heel of the right sneaker was folded down on top of the sneaker lining. Resident #30 reported shoes were not comfortable and he/she could not get the entire foot in to the shoe and needed a bigger pair of shoes.</p> <p>The surveyor leaned forward to look at the fit of the shoe and noted an unpleasant odor from the shoe. When the resident pulled the right foot out of the sneaker the lower portion of the foot had a white dressing wrapped around it. The size of the foot with the dressing did not fit inside the end of the sneaker. Resident #30 reported the shoe had been saturated with infection and smelled and staff washed the shoe.</p> <p>Staff O, present at this time, reported he/she had not noticed a problem with the shoe or reported the sneaker and had not seen it folded down. Staff O also reported the facility glued the shoes before because they came apart and Staff A and Staff S were aware of the shoe problem.</p> <p>On 1/24/14 at 11:35 a.m. Staff AAA reported Resident #30 puts own shoes on and had not noticed a problem with odor from the shoes and</p>	F 309		3/10/14

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F 309	<p>Continued From page 41</p> <p>had not reported a problem related to the fit of the shoe.</p> <p>A hospital Emergency Services Report noted 5/15/13 documented Resident #30 had worsening of chronic lower extremity edema and decreased sensation of the right leg and chronic thickening of the skin on the right foot.</p> <p>A care plan with a problem start date of 6/11/13 for an actual open area to the right lower extremity, venous insufficiency and bilateral lower extremity lymphedema included an approach to "prevent injury/trauma to feet - ensure proper footwear."</p> <p>A Quarterly nursing Assessment dated 12/3/13 documented the resident had chronic edema to both lower legs, received antibiotic treatment for an ulcer infection on the second right toe, wore specialty dressings on both legs and went to weekly appointments at a wound clinic.</p> <p>Wound clinic notes dated 12/30/13 and 1/6/14 both documented the resident continued to have specialty medicated dressings applied to both legs.</p> <p>On 1/24/14 at 1:06 p.m. Staff B reported Resident #30 went to the wound clinic for treatment of lymphedema ulcers. Staff B also reported the resident's toes were filled with fluid. Skin monitoring sheets provided by Staff B documented the resident had an improving vascular ulcer on the second right toe with serous drainage noted on 1/23/14.</p> <p>When asked if nursing assessed the fit of shoes for residents with foot ulcers, Staff B reported I</p>	F 309			3/10/14

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

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F 309	<p>Continued From page 42 think it would be "common sense."</p> <p>Resident #30's medical record did not contain evidence staff assessed the fit of the resident's sneakers to ensure they did not add compression to an already swollen extremity and current ulcer on the toe or ensured they followed the resident's plan of care for proper footwear.</p> <p>The facility failed to assess the fit of shoes Resident #30 had available to wear to ensure shoes were large enough for an edematous foot with healing ulcer and foot with decreased sensation. The facility also failed to provide evidence they addressed the concern that wound drainage that saturated the shoe and history of previous foot infection did not contribute to risk of repeat foot infections. These failures had the potential to impair healing of the resident's foot ulcer from further impaired circulation and risk for re-injury of skin.</p> <p>RESIDENT #156 - MONITOR BRUISES Review of the Minimum Data Set (MDS) Admission Assessment dated [REDACTED] listed Active Diagnosis to include [REDACTED] [REDACTED] The facility's diagnosis list records a personal history of [REDACTED] with a [REDACTED]. Treatment with the medication [REDACTED] with one of several uses to prevent unwanted blood clots was ordered on the resident's medication list.</p> <p>On 1/29/14 at 11:01 a.m., a review of the admission Progress Note dated 1/10/14 records Resident #156's "skin intact with scattered</p>	F 309		3/10/14

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F 309	<p>Continued From page 43</p> <p>bruises in the mid upper chest and on both lower arms, said skin is easy to bruise. Discoloration on both lower legs, daughter said related to poor circulation." An entry dated 1/26/14 was the second progress note entry documenting the resident's skin status and coincided with a visit by Resident #156 family member who requested treatment for dry patchy areas behind the residents left ear.</p> <p>The Admission and Weekly Skin Observation Tool initiated by Staff CCC on 1/10/14 recorded Resident #156 to have scattered bruises on upper chest, left and right forearm, and discoloration of right and left lower leg. The second entry dated 1/26/14 recorded the resident to have multiple bruises to chest and multiple bruises to left and right forearms. Documentation did not address the discoloration to both lower legs recorded on the initial assessment or the skin area behind the left ear.</p> <p>During an interview on 1/29/14, Staff O stated Resident #156's bruising is monitored on the skin sheets in the treatment book. She/he said the same nurse did not always monitor the resident's skin each week. Staff O was not able to state whether the current bruising on Residents #156 chest and extremities had improved or worsened since the initial admission assessment.</p> <p>Resident #156's record reviewed on 1/29/14 did not identify a specific care plan or care directive related to skin bruising that included measurable goals and specific interventions for staff to follow. Skin monitoring records used were difficult to track and did not contain consistent wound monitoring or terminology to identify the color, shape, extent of skin area with bruising or change</p>	F 309		2/10/14

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F 309	<p>Continued From page 44 in the presentation of the bruising.</p> <p>During an interview on 1/30/14 at 8:32 a.m., Staff D said weekly skin checks were recorded on the Treatment Administration Record (TAR) and all skin issues are documented in the Admit nurse database. Staff D stated the day following a resident's admission the Residential Care Manager (RCM) assesses the skin and determines the skin status. Staff D stated she/he had not documented a RCM note on Resident #156 skin status.</p> <p>Staff D further stated Skin issues are put on the skin sheets that go with the treatment sheet and were updated if the skin was healing or improving. A monitoring sheet was created within 24 hours of admission and Resident #156 was not documented on weekly wound records.</p> <p>Staff D explained Resident #156 recieved aspirin and [REDACTED] which could increase the risk of bleeding and bruising. She/he said staff working with the resident should notify the nurse regarding any skin issues. Staff D stated that measures put in place for residents with a risk for bleeding and bruising, depending on the person, would be to wear long sleeves, or wear geri-sleeves to protect the extremities. Staff D stated she/he did not know if an increase in bruising was noted for Resident #156 since admission.</p> <p>Failure to conduct a comprehensive assessment of the skin bruising on admission, consistently monitor, describe and document skin observations on skin monitoring records or consistently monitor for changes in bruising had the potential for all staff to not have adequate information to compare the current condition of</p>	F 309		3/10/14	

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F 309	Continued From page 45 the bruising with the previous condition and to determine if physician notification and a change in treatment were necessary.	F 309		3/10/14	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure staff obtained valid medical justification for use of indwelling foley catheters for 2 of 3 Sampled Residents (#s 12 & 59) reviewed for catheters of the 53 residents who were included in the Stage 2 review. Failure to ensure adequate indication for use and a plan for timely removal of indwelling catheters placed these residents at risk for urinary tract infections and decline of normal bladder function. Findings include:	F 315	F315 Residents #12 and #59 remain in the facility. Resident #12 has updated diagnoses to include justification for catheter. Resident #59 had catheter removed. Residents with catheters were reviewed to ensure that clinical condition demonstrates a catheter is necessary. Random audits of residents with catheters will be completed to ensure that clinical condition demonstrates a catheter is necessary.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 315	Continued From page 46 RESIDENT # 59 Review of the Minimum Data Set (MDS) Admission Assessment dated [REDACTED] lists active diagnoses of [REDACTED]. The facility diagnosis lists includes [REDACTED]. Review of the Care Area Assessment (CAA) Summary list triggers: ADLs Functional Status/Rehab Potential; Urinary Incontinence and indwelling Catheter; Review of the Care Area Assessment (CAA) Detail Report dated 12/11/13 for Urinary Incontinence and Indwelling Catheter records CAA Triggers: Extensive Assistance = yes - Toilet use self-performance problem is indicated. Indwelling catheter is indicated. - Indicators for use: psych problems, pain, restricted mobility - Factors that contribute to incontinence or catheter use: None listed - Diseases and conditions: [REDACTED] - Type of Incontinence: None listed - Use of catheter: None listed On 1/24/14 at 11:11 a.m., when asked why the catheter was placed, Resident # 59 did not recall being given a reason or diagnosis for placing the catheter. The resident also reported having the catheter 9-10 months before coming to the facility, "Think it was put in just because they had no time to get me up and I had no strength to get up." During an interview with Staff C on 1/27/14 at	F 315	Progress and trends of audits will be reported during monthly QAPI meeting. DNS or designee will be responsible to ensure correction	3/10/14	

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F 315	<p>Continued From page 47</p> <p>12:22 p.m., she/he said had spoken to Resident #59 and the resident said the catheter was placed at the time of prior surgery. When asked the facility practice/protocol when residents were admitted to the facility with indwelling catheters. Staff C reported they should assess the need for the catheter, look for a supporting diagnosis and rule out a medical need. If the catheter was not needed the facility would request and order from provider to discontinue the catheter use and monitor voiding.</p> <p>RESIDENT #12 Resident # 12 was admitted to the facility on [REDACTED] from the hospital with an indwelling urinary catheter (a tube that drains urine from the bladder). Review of hospital records did not indicate why Resident # 12 had an indwelling urinary catheter.</p> <p>On 1/22/14 at 1:31 p.m. Resident #12 sitting in wheelchair with a Foley catheter tube training amber colored urine.</p> <p>Review of facility policy titled "Indwelling Urinary Catheter", indicates all residents who admit to the facility with an indwelling urinary catheter must have an appropriate medical justification.</p> <p>On 1/27/14 at 1:13 p.m. Staff Y reported that Resident #12 had an indwelling urinary catheter since admitting to the facility. Staff Y reported that the reason for the indwelling urinary catheter "was a grey area" and the diagnosis for catheter had not been determined. Staff Y reported that facility had not confirmed justification for the catheter.</p>	F 315		3/10/14

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F 315	Continued From page 48 Review of Resident # 12's indwelling catheter care plan revealed an intervention for a urology consult. Review of Resident # 12's medical record failed to provide evidence of a urology referral or consult. The failure to obtain medical justification for the use of Resident # 12's indwelling Foley catheter placed the resident at potential risk for unnecessary use.	F 315		3/10/14	
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 review it was determined the facility failed to adequately supervise residents to ensure safe smoking practices were implemented for 3 of 7 Sampled Residents (#s 9, 28 & 82) assessed as dependent smokers and 2 of 13 Sampled Residents (#s 41 & 158) assessed as independent smokers of the 53 residents who were included in the Stage 2 review. This had the potential to place residents at risk for smoking related injuries.	F 323	F323 Resident #128 was reeducated on using the smoking receptacles provided. Resident #157 is no longer in facility.		

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F 323	<p>Continued From page 49</p> <p>Findings include:</p> <p>INDEPENDENT SMOKING CANOPY On 1/21/14 at 10:40 a.m. three residents sat and smoked beneath a canopy in the courtyard around edges of a table. Resident #128 and another unidentified resident sat a distance from the only smoking stem receptacle present in the area and dropped ashes on the pavement around them. Cigarette butts covered the pavement beneath the smoking canopy too numerous to count.</p> <p>The area within the courtyard contained a BBQ grill with propane tank beneath. A cigarette butt rested on a shelf directly next to the propane tank.</p> <p>The covered smoking space did not contain an emergency call system or means of communication for residents to alert staff if needed.</p> <p>On 1/21/14 at 10:40 a.m. Resident #157 sat in a wheelchair and smoked outside on a cold day beneath the smoking canopy. The resident, who did not wear any foot covering, had both feet exposed and reported "I can't feel my feet" and stated it took too much work to put on shoes. The second toe on the resident's foot had a small darkened area on it. The resident also reported he dropped ashes on own toes in the past.</p> <p>Resident #157's January 2013 physician orders included an order dated 1/21/14 to administer a medication that thinned blood and increased risk for bruising. A second order dated 1/8/14 directed staff to monitor bruises to bilateral arms and</p>	F 323	<p>Cigarette butts have been removed from area.</p> <p>Radio devices have been set up for use in the smoking area to alert nursing if needed.</p> <p>Smoking next to dining area is no longer allowed.</p> <p>Smoking receptacles have been cleaned.</p> <p>Resident #41 was reeducated on smoking policy.</p> <p>Resident #158 is no longer in facility.</p> <p>Resident #82 was reeducated on smoking policy.</p> <p>Staff has been reeducated on smoking interventions and immediate intervention tools have been placed visibly on the dependant smoker's material box.</p> <p>Smokers have been reassessed through several observations to assure appropriate level of</p>	2/10/14
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F 323	<p>Continued From page 50</p> <p>second toe of the left foot. Staff were not present to monitor Resident #157 and ensure feet were protected from injury and the cold.</p> <p>On 1/21/14 at 1:21 p.m. Resident #26 smoked beneath the smoking canopy. A fire extinguisher and another box identified as a smoking blanket were attached to one of the poles of the canopy. Resident #26 reported if he/she would throw the blanket on someone if they caught on fire but no one instructed him/her how to use the fire blanket.</p> <p>On 1/22/14 at 9:09 a.m. two unidentified residents sat in wheelchairs and exited the C Wing door that lead to the smoking area. Both residents stopped within approximately six to 10 feet outside the door and began to smoke. Neither resident smoked within the designated smoking area. Both residents smoked and dropped cigarette ashes on the ground near their wheelchairs. The pavement surrounding one resident contained a cigarette butt. Staff were not present to supervise.</p> <p>On 1/22/14 at 3:34 p.m. Staff A reported hearing complaints of cigarette butts on the ground through housekeeping checks and residents should use the enclosed smoking receptacles to dispose of cigarette butts. Staff A also reported part of the smoking assessment included how residents disposed of their cigarette butts and were capable of doing that task.</p> <p>Staff A reported he did not identify any concerns with residents who smoked independently. When asked how residents would alert staff for help when in the courtyard, Staff A reported they would have to come inside the building. Staff A also</p>	F 323	<p>independent/dependant smoking status.</p> <p>Smokers have been unobtrusively observed to assure compliance.</p> <p>Smoking assessment policy has been updated to include ongoing assessments and observed compliance.</p> <p>Staff has been educated on assuring residents have appropriate foot wear when in smoking area.</p> <p>Residents who smoke have been instructed on use of fire blanket and fire extinguisher.</p> <p>Instruction on use of fire extinguisher and fire blanket has been placed in smoking area.</p> <p>Staff has been educated on safety approaches and dependant smokers.</p> <p>Staff has been educated on assuring dependant times for smoking occurs on time.</p>	3/10/14

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F 323	<p>Continued From page 51</p> <p>reported residents were not instructed about the fire blanket and the fire extinguisher. Staff B reported residents were instructed to dispose cigarettes in the receptacles.</p> <p>SUPERVISED SMOKING AREA NEXT TO THE DINING ROOM</p> <p>On 1/21/14 at 12:37 p.m. an unidentified resident smoked on the patio just outside the Main Dining Room during the noon meal. The smell of smoke wafted throughout the dining room. The resident who smoked was clearly visible to dining room staff through the window. A sign on the exit door stated <i>no smoking in that area during dining and activities</i>. Staff did not intervene.</p> <p>On 1/21/14 at 1:21 p.m. the bases of multiple smoking stemmed receptacles outside the dining room smoking area were heavily coated with cigarette ashes.</p> <p>On 1/22/14 at 11:30 a.m. to 12:05 p.m. a long crack down the center of the smoking area that measured approximately 1/2 inch wide was filled with multiple cigarette butts. There were 4 smoking stem receptacles that had wide bases that measured approximately two feet wide and were heavily covered with cigarette ashes.</p> <p>AFTER CLOSURE OF THE SMOKING AREA NEXT TO THE DINING ROOM</p> <p>On 1/23/14, due to a finding by the Fire Marshall, the smoking area next to the dining room was closed and the smoking canopy was the only location designated for both supervised and unsupervised resident smoking. After this change, the following observations were made:</p>	F 323	<p>Managers have been assigned rounds to assure staff and resident compliance with smoking policy.</p> <p>Random audits of smoking area will be completed to assure compliance.</p> <p>Progress and trends of audits will be reported during monthly QAPI meeting.</p> <p>Administrator or designee to ensure compliance</p>	3/10/14
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F 323	<p>Continued From page 52</p> <p>On 1/27/14 at 11:19 p.m., Resident # 41 was seated in his/her wheelchair, smoking in an area not authorized for smoking just outside the covered area off the dining room.</p> <p>On 1/27/14 at 1:56 p.m., Resident #158 was sitting in his/her wheelchair smoking just outside the covered area off the main dining room, an area not authorized for smoking.</p> <p>Resident #158 was observed putting an extinguished cigarette butt into his/her coat pocket. The resident stated it was difficult to propel the wheelchair all the way to the smoking canopy and, since there were no smoking stem receptacles where he/she was sitting, the resident put them in his/her pocket so staff would not have to clean them up off the ground.</p> <p>Resident #158 produced approximately 10 cigarette butts from his/her pocket and said he/she had been discarding the butts into his/her pocket for about three weeks. Resident #158 did not know if staff were aware of this practice.</p> <p>On 1/11/14 documents identified staff assessed Resident #158 and determined the resident safe to smoke independently. On 1/27/14 at 2:25 p.m., Staff B reported staff initially observed all residents to determine ability to practice safe smoking. The assessment process did not include continued monitoring through follow up observations after the initial assessment.</p> <p>The following observations were made on 1/27/14:</p> <p>At 2:58 p.m., Resident #41 was seated in his/her wheelchair approximately 20 feet outside the</p>	F 323		3/10/14

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F 323	<p>Continued From page 53</p> <p>smoking canopy, near the fence at the far corner of the courtyard.</p> <p>A daily supervised smoking session was scheduled from 3:00 to 3:15 p.m. at the smoking canopy. At 3:00 Staff were not present to supervise.</p> <p>At 3:10 p.m., Resident #41, an independent smoker, moved to within 10 feet of the smoking canopy where resident #82 was sitting. Resident #41 gave a cigarette to Resident #82 who required staff supervision for smoking. Resident #41 lit the cigarette for Resident #82.</p> <p>At 3:12 p.m., Staff DDD arrived to staff the supervised smoking session. Staff DDD said he/she was late because he/she had been busy caring for a resident.</p> <p>On 1/28/14, a safety plan had been implemented to staff the smoking canopy 24 hours per day.</p> <p>On 1/28/14, in the late afternoon, a change of staff was observed at the smoking canopy. Staff AAA was leaving as Staff V arrived. Staff V gave a cigarette to Resident #28 and lit it. Resident #28 was observed to have a severe tremor and the resident's hand shook holding the lit cigarette for approximately one to two minutes before Staff V put a protective smoking apron on the resident.</p> <p>The facility failed to adequately supervise residents to ensure safe smoking practices were implemented, placing residents at risk for smoking related injuries.</p>	F 323		3/10/14

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F 332 F 332 SS=D	Continued From page 54 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to maintain a medication error rate of less than 5%. Licensed staff failed to follow all physician orders for 1 Sampled Resident (#37) during 2 of 26 medication administration observations, resulting in an error rate of 7.69%. This failure had the potential to diminish therapeutic effectiveness of medication for the resident. Findings include: Resident #37 was initially admitted to the facility on [REDACTED] and re-admitted on [REDACTED] with diagnoses to include [REDACTED] On 1/24/14, Resident #37's physician orders included the following: 1) May crush crushable medications. 2) [REDACTED] (extended release) 24 hour tablet, 25 milligrams (mg) by mouth every morning. Check apical pulse prior to admission and hold for heart rate less than 60. Do not crush. 3) Caltrate plus D tablet 600 mg by mouth twice daily.	F 332 F 332	F332 Resident #37 remains in the facility and had no adverse effects Re-education was done with LN's related to non-crushable medications and pulse monitoring related to [REDACTED] Random audits of medication administration will be completed to ensure non-crushable medications and pulse monitoring related to [REDACTED] is completed per physician orders and manufacturer recommendations. Progress and trends of audits will be reported during monthly QAPI meeting.	3/10/14	

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F 332	<p>Continued From page 55</p> <p>On 1/24/14 at 7:16 a.m., during observation of medication administration, the following was observed:</p> <ol style="list-style-type: none"> 1) The orders for [REDACTED] and caltrate were transcribed correctly on the Medications Flowsheet (MAR), including instructions "Do not crush" [REDACTED] 2) Staff G prepared all Resident #37's morning medications, including [REDACTED] by crushing them and mixing with applesauce, even though the order said do not crush [REDACTED] 3) Staff G did not check Resident #37's pulse as ordered before administering [REDACTED] 4) Staff G administered only one caltrate 200mg tablet instead of 3 caltrate tablets for a dose of 600 mg as ordered. 5) Staff G documented all the medications administered on the MAR except [REDACTED] <p>On 1/24/14 at 11:09 a.m., Staff G stated, "I should have given 3 caltrate 200 mg tablets, but only gave one tablet. ...I should have taken a pulse before administering [REDACTED] but did not. ...I should have documented the [REDACTED] and forgot." Staff G said he/she was unaware of any special exception to the order "Do not crush" [REDACTED]</p> <p>These failures to follow all physician orders for Resident #37 had the potential to diminish therapeutic effectiveness of the resident's medication.</p>	F 332	DNS or designee will be responsible to ensure correction	3/10/14

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F 332	Continued From page 56	F 332		<i>3/10/14</i>
F 364 SS=D	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was the determined the facility failed to consistently serve food at palatably warm temperatures to ensure resident satisfaction of meals on 1 of 4 Wings (A Wing). This had the potential to place residents at risk for diminished quality of life and compromise nutritional status.</p> <p>Findings include:</p> <p>On 1/21/14 at 12:01 p.m., when asked if food was served at the proper temperature, Resident #35 said the food "comes cold a lot."</p> <p>On 1/21/14 at 1:45 p.m., when asked if food was served at the proper temperature, Resident #21 reported, "We've been getting it cold lately." The resident said it was no specific meal, stating all meals were served too cold.</p> <p>On 1/22/14 at 8:56 a.m., when asked if food was served at the proper temperature, Resident #59 stated, "Some days it's cold. I don't know who to tell."</p>	F 364	<p>F364</p> <p>Resident #35, #21, #59, #115 has been educated to ask staff to warm food up if not hot enough per their preference.</p> <p>Residents have been educated to ask staff to warm food up if not hot enough per their preference.</p> <p>Insulated carts were provided to all halls to assure proper food temperature.</p> <p>Random audits of food temperatures will be completed to assure insulated carts are maintaining food temperatures.</p> <p>Progress and trends of audits will be reported during monthly QAPI meeting.</p>	

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F 364	<p>Continued From page 57</p> <p>On 1/22/14 at 9:10 a.m., Resident #115 reported that food which should be served warm was often not warm enough. The resident stated he/she eats meals in his/her room.</p> <p>On 1/24/14 at 1:10 p.m. Dietary Staff Z reported not all food carts were insulated. Staff Z reported it was random which ones were and which ones weren't.</p> <p>On 1/27/14 between 11:53 a.m. and 12:00 p.m., Staff HH used a facility thermometer to test temperature of food on the steam table and stove in the kitchen staff served onto plates for residents to eat.</p> <p>Staff HH took plates from a plate warming container and placed them onto burgundy colored pallets (bottoms). Staff HH reported burgundy bottoms (pallets) plates staff served food on were not heated.</p> <p>Staff HH reported the following temperatures validated by the surveyor:</p> <p>Chicken Patty: 152.6 degrees Fahrenheit (F) Sliced ham: 163 degrees F Ground ham: 146.4 degrees F Whipped yams: 197.1 degrees F Mixed vegetables: 186.3 degrees F</p> <p>On 1/27/14 at 12:00 p.m. the surveyor asked kitchen staff to add an extra lunch-tray to the cart delivering lunch trays to the A Wing for residents eating in their rooms. At 12:07 p.m., hall trays were delivered to A Wing in a non-insulated metal cart and staff immediately served trays to residents.</p>	F 364	Administrator or designee to ensure compliance	3/10/14	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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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 364	<p>Continued From page 58</p> <p>On 1/27/14 at 12:13 p.m. Staff GG reported the top plates (on the plate warmer) were not as hot as the plates on the bottom.</p> <p>The final resident tray was delivered at 12:14, at which time Staff GG immediately joined the surveyor to test food temperatures on the extra tray.</p> <p>Staff GG agreed with the surveyor's observation that plates had bottom and top covers with no heated pallet beneath the plates.</p> <p>With Staff GG using the facility thermometer, the following food temperatures were recorded:</p> <p>Chicken Patty: 98.7 degrees F Sliced ham: 101.6 degrees F Ground ham: 107.3 degrees F Whipped yams: 147.2 degrees F Mixed vegetables: 123 degrees F</p> <p>All food items tested revealed temperatures dropped considerable amounts from the time temperatures were taken on the steam table immediately at time of food service in the kitchen to the time the last food tray was served to residents.</p> <p>Food items tested at the end of meal delivery revealed food temperatures dropped by the following:</p> <p>Chicken Patty: loss of 53.9 degrees F Sliced ham: loss of 61.4 degrees F Ground ham: loss of 40.1 degrees F Whipped yams: loss of 49.9 degrees F Mixed vegetables: loss of 63.3 degrees F</p>	F 364		3/20/14

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F 364	<p>Continued From page 59</p> <p>Hot food temperatures did not remain consistently hot at the end of meal service when served to residents.</p> <p>According to Federal regulation 483.35(i)(2), F Tag 371, "The facility must - ... (2) Store, prepare, distribute and serve food under sanitary conditions." Surveyor investigative protocols identified, "Cold foods should be at or below 41 degrees F when served. Hot foods should be at 135 degrees F or above when served."</p> <p>On 1/27/14 at 12:21 p.m. following meal service, when asked about his/her lunch, Resident #132 who resided on the A Wing stated, "Everything is cold."</p> <p>On 1/27/14 at 12:35 p.m., Staff UU confirmed that the facility did not use heated plates or heated pallets under the plates. Staff UU used a laser thermometer to test the temperature of plates stacked in a receptacle next to the tray line in the kitchen, which recorded a temperature of 93 degrees F.</p> <p>The temperature of plates at 93 degrees F does not support maintenance of hot food temperature to maintain a minimum of 135 degrees or above when served.</p> <p>On 1/30/14 at 9:55 a.m. Resident #38, reported that plates were never warm and "they should be warm to keep the food temperatures hot."</p> <p>Failure to ensure plates were hot at time of food service and/or pallets which held plates were heated and food carts were insulated prevented hot food in the kitchen to remain hot when served to residents.</p>	F 364		3/10/14

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F 364	Continued From page 60 Failure to ensure food remained palatably warm at time of meal service had the potential to decrease resident quality of life and/or discourage residents from consuming their entire meal and/or lose weight over time.	F 364		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that food was stored, prepared, distributed and served under sanitary conditions. This had the potential to place residents at risk for potential food borne illnesses. Findings include: On 1/21/14 at 09:10 a.m. during the initial tour in the kitchen the following was observed: The refrigerator contained one package of sausage and three packages of meat that were unlabeled. Staff Z, present at the time, reported	F 371	F371 Meat has been labeled and dated. Out dated pudding and unlabeled cheese, lettuce and salad has been thrown away. Fan over dishwasher has been cleaned. Area behind oven has been cleaned. Dry storage area has been cleaned.	3/10/14

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F 371	<p>Continued From page 61</p> <p>she was not aware of this. The refrigerator had a metal container on the top shelf with pudding dated 2012 on the plastic wrap cover. Staff Z, stated the date must be a mistake and removed the pudding. Staff Z also removed undated opened cheese, undated opened bagged lettuce, and an opened salad container.</p> <p>The fan over the dishwasher was matted with dark particle substances. The area behind the oven contained residue that covered metal components that connected to the oven.</p> <p>In the dry storage area there were random packets of peanut butter on the floor.</p> <p>The following day on 1/22/14 at 7:30 a.m., Staff UU reported "all meats from yesterday had been just removed from the freezer, but not being marked in any way, including expiration dates, was not right."</p> <p>On 1/24/14 at 2:00 p.m. during an interview with Staff P regarding housekeeping services in the kitchen reported "We've never done anything in the kitchen; the administrator wants high dusting in kitchen and for me to make a schedule for that; schedule is under construction. We would clean the fans with degreaser and probably this week will do that."</p> <p>On 1/24/14 at 2:40 p.m. Staff Q stated the "oven and other items are on a schedule for cleaning" Staff Q reported there was no documentation of the cleaning schedule.</p> <p>On 1/27/14 at 12:15 p.m. Staff UU provided cleaning lists of cleaning responsibilities by dietary aides, cooks, and prep cooks. Staff UU</p>	F 371	<p>Cleaning schedules have been update to include initialing when cleaning duties are completed.</p> <p>Health shakes on nursing carts have been put on ice to keep cold.</p> <p>Resident food in refrigerators are labeled and dated.</p> <p>Dietary manager is doing random rounds on resident refrigerators to assure all resident food is labeled and dated.</p> <p>Staff has been reeducated on labeling and dating resident food that is put in resident refrigerators.</p> <p>LN's have been reeducated on assuring health shakes are keep on ice to keep cold.</p> <p>Random audits of refrigerators will be completed to assure compliance.</p> <p>Random audits of nursing carts will be completed to assure health shakes are being put on ice and kept cold.</p>	3/10/14	

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F 371	<p>Continued From page 62</p> <p>stated there was no documentation of what had been cleaned in the kitchen, when or by whom.</p> <p>HEALTH SHAKES On 1/30/14 at 1:52 p.m., medication storage observation of the D Wing medication cart was conducted with Staff G whose shift had just begun. A thin hard plastic tray measuring approximately 4 x 10 inches by 3 inches deep, for keeping refreshments used during medication pass, was sitting on top of the cart. The inside of the tray was dry and contained two 4 ounce sealed cartons of health shake. When the surveyor noted that the two cartons of health shake felt warm, Staff G said the cartons were left over from the previous shift and Staff G planned to refresh the tray for use during his/her shift.</p> <p>At approximately 2:00 p.m., Staff G was observed to place the tray, half full of ice, on top of the medication cart and place the original two health shake cartons back into the tray. The surveyor opened one of the shakes and, using a digital thermometer, observed the temperature of the health shake was 66.3 degrees Fahrenheit (F).</p> <p>The storage instructions on the container read, "Store frozen. Thaw under refrigeration (40 F or below)."</p> <p>RESIDENT FOOD REFRIGERATOR IN A/B WING NURSING STATION On 1/30/14 at 9:40 a.m., the refrigerator for storing resident food, located at the back of the A/B Wing nursing station, contained two paper plates covered with tin foil. Neither of the plates had a date identifying when it was placed in the</p>	F 371	<p>Random audits of kitchen food and cleaning schedules will be completed to assure compliance.</p> <p>Progress and trends of audits will be reported during monthly QAPI meeting.</p> <p>Administrator or designee to ensure compliance</p>	3/10/14

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F 371	Continued From page 63 refrigerator. Staff G said the two plates belonged to Resident #113 and Resident #62 and said each plate should have been labeled with the date it was placed in the refrigerator.	F 371		3/10/14
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to assist in obtaining routine dental care for 1 of 3 Sampled Residents (# 59) reviewed for dental needs of the 53 residents who were included in the Stage 2 review. This failure placed the resident at risk to not receive dental services to meet needs of the resident. Findings include:	F 411	F411 Resident #59 remains in the facility and has been seen by the dentist. Audit will be completed of comprehensive assessments to ensure that dental referrals were made as needed. Nurses completing comprehensive assessments were re-educated to the referral process.	

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F 411	<p>Continued From page 64</p> <p>Refer to F279 for Comprehensive Care Plans</p> <p>The Analysis of Findings summary recorded in the CAA Detail report dated 12/11/13 stated "Resident with poor dentition, missing, broken, carious teeth which resident states has dental pain when she/he chews. Resident requires set up and encouraged to perform adequate oral care. Resident is at risk for declines in dental status. Staff to monitor declines and treat issues. Staff to monitor appropriateness of diet texture, provide encouragement and assist with oral care."</p> <p>During an interview on 1/27/14 at 10:28 a.m., Staff R and Staff S reported that nursing kept a dentist referral book. If the dental need was emergent staff would refer resident in as soon as possible. On admit nurses did a head tt toe evaluation. When doing the initial referral assessment if mentioned, staff would put resident's name in referral book or tell the nurses who would do it.</p> <p>On 1/29/14 at 12:50 p.m., Staff D stated dental issues were identified by disciplines to include social services. Issues identified would be reported to Nursing for referral. All disciplines can enter resident names into the referral log. Another option included placing the resident's name into a 24 Hour book located at each nurses' station.</p> <p>On 1/27/14 Staff J and Staff H stated they were unaware of any dental issues regarding Resident #59. If a complaint of pain was reported by a resident, emergent cases would be called to the provider or otherwise their name placed on Log to be seen.</p>	F 411	<p>Random audits of comprehensive assessments will be completed to ensure that nurses are following physician orders and manufacturer recommendations.</p> <p>Progress and trends of audits will be reported during monthly QAPI meeting.</p> <p>DNS or designee will be responsible to ensure correction</p>	3/10/14

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F 411	Continued From page 65 On 1/27/14 at 11:23 a.m., Staff U said she was responsible for scheduling the dentist and other consult services. Following a search of the dentist schedule log, Staff U confirmed Resident #59's had not been placed on the list for dentist visit. Staff U confirmed that in emergent cases the dentist comes to facility depending on resident's condition or the resident would be sent out for dental care. When it was known a resident needs to be seen, information would be faxed to the dentist who visits every 60-90 days.	F 411		3/10/14
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441	F441 Laundry staff, including Staff LL, has been reeducated on removing gloves and washing hands during laundry process. Laundry staff, including Staff LL, has been reeducated on proper technique of wiping rim of washer in between laundry loads.	

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F 441	<p>Continued From page 66 isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to ensure staff followed laundry procedures to prevent cross contamination of linen and could identify when to check washing machine temperatures. Failure to prevent cross contamination of linen and to not be able to identify if adequate washing machine temperatures were reached had the potential to place residents at risk for spread of infection through un-sanitized linen.</p> <p>Findings include: During observations in the laundry on 1/29/14 beginning 12:11 p.m. Staff LL donned a gown, gloves and mask and entered the sorting room in the laundry. Staff LL removed soiled linen from plastic bags and placed them in a large barrel and reported linens could contain feces.</p>	F 441	<p>Laundry staff, including Staff LL, has been reeducated on how to take proper temperatures on washing machines.</p> <p>Random audits of laundry procedures will be completed to assure compliance.</p> <p>Progress and trends of audits will be reported during monthly QAPI meeting.</p> <p>Administrator or designee to ensure compliance</p>	3/10/14

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F 441	<p>Continued From page 67</p> <p>After filling the barrel, Staff LL kept contaminated gloves on and handled the doorknob to the door to open it to enter the laundering area with washing machines and dryers. Staff LL opened the washing machine door while wearing the same pair of contaminated gloves worn to sort soiled linen.</p> <p>Staff LL continued to handle soiled linen and placed it in a washing machine. While filling the machine, soiled linen glided over the lower rim of the machine potentially contaminating the lower rim.</p> <p>After filling the washing machine Staff LL used a disinfectant to wipe the inside of the washing machine door. While continuing to wear the same pair of contaminated gloves, Staff LL touched the handle of the sorting room door to reenter the sorting room.</p> <p>Following removal of contaminated gloves Staff LL did not wash hands prior to entering the room that contained residents' personal clothing and before handling and processing resident personal clothing.</p> <p>Throughout observations of laundry sorting and filling washing machines, soiled linen contaminated the lower inside washing machine rims; staff gloved hands that handled soiled linen contaminated door handles on both sides of the door to the sorting room and handles of the washing machine. Staff LL did not wash hands following removal of contaminated gloves.</p> <p>During an interview following observations Staff LL reported he/she filled in for the day and usually</p>	F 441		3/10/14

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F 441	<p>Continued From page 68</p> <p>worked in a different role in the building. Staff LL also reported he/she had not worked in the laundry for the past eight months. When asked what needed to be disinfected after filling washing machines with soiled linen, Staff LL did not identify the need to disinfect the lower rims of the washing machine.</p> <p>During continued observation of the laundering cycles, Staff LL checked water temperatures multiple times and reported the water temperatures needed to reach 154 degrees Fahrenheit (F) to 160 degrees F. Staff LL also showed a temperature log that staff logged water temperatures daily.</p> <p>At 12:12 p.m., when asked what part of the laundering cycle needed to be checked to determine if the required temperatures were reached, Staff LL did not know.</p> <p>Upon loading cleaned linen in the washing machine, Staff LL emptied the washer and glided clean linen over the lower rim of the washer without first disinfecting it. This had the potential to re-contaminate cleaned linen.</p> <p>Staff P reported Staff LL received training in laundry procedures eight months ago. The surveyor asked Staff P to provide evidence Staff LL received training in laundry procedures and copies of laundry procedures. Staff P reported he/she would look for training records but the previous housekeeping supervisor did not leave any records.</p> <p>Staff P also reported Staff LL should wash hands after removing gloves after handling soiled linen.</p>	F 441		3/10/14

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F 441	Continued From page 69 A sign on the bulletin board in the laundry on 1/29/14 at 12:12 p.m. stated "Sanitizing Washing Machines prior to Use: after filling the washing machine with dirty laundry wipe the rim of the washer with disinfectant to keep clean laundry from touching contaminated surfaces once the laundry load is finished." Facility policies and procedures for laundry provided on 1/29/14 at 3:19 p.m. identified there were four factors in sanitizing linens that included dilution; agitation; temperature and chemicals. The facility did not provide evidence Staff LL, who had not worked in the laundry for eight months, received initial training or re-training specific to laundry room procedures before being re-assigned to a previous duty he/she had not worked in for some time to ensure laundry procedures were followed.	F 441		3/10/14	
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to provide a comfortable and functional work environment for residents and staff in 3 of 4 Shower Rooms (A Wing, B Wing and D Wing); 1	F 465	F465 D wing shower room is fully functional. B Wing shower tile has been repaired. B wing shower room ceiling fan has been repaired.		

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F 465	<p>Continued From page 70 of 2 Nursing Stations (C/D Wings); 1 of 2 Medication Rooms (C/D Wings) and in the Laundry. This had the potential to compromise dignity and quality of life for residents related to shower needs; for staff to not have ready access to hand washing stations to prevent spread of infection and/or to delay treatment of eye injuries due to lack of immediate access to an eye wash station in the laundry.</p> <p>Findings include:</p> <p>Refer to F 253 and F 241 related to additional observations and interviews for housekeeping and dignity concerns related to the environment.</p> <p>D WING SHOWER Residents who resided on the rear unit D Wing were transported to the front of the building to the A Wing to shower due to a nonfunctional shower located on the D Wing. Resident census sheets provided on 2/4/14 identified on 2/4/14 there were 27 residents who resided on D Wing.</p> <p>Shower records provided on 2/4/14 identified all residents on the D Wing showered except one resident who preferred a bed bath. Facility measurements provided on 2/5/14 at 12:10 p.m. identified residents on the D Wing had to travel more than 300 feet to access the shower on the A Wing.</p> <p>On 1/28/14 at 12:49 p.m. Staff L reported concerns residents got cold being transported to the other side of the building to get showered (D Wing to A Wing).</p> <p>On 1/29/14 at 11:52 a.m. Resident # 36 who resided on the D Wing reported she had to go</p>	F 465	<p>A wing shower drain covers are in place.</p> <p>Nursing staff has been provided shower keys.</p> <p>Nursing station sink and eye wash station has been removed.</p> <p>Staff has been instructed to use functional eye wash station and sink located in main dining room if needed.</p> <p>Location of eye wash stations will be reviewed during general orientation and during all staff meetings annually.</p> <p>Sink in room across hall is available and instructions on how to open door has been posted.</p> <p>Eye wash station in laundry room has been repaired.</p> <p>Lighting in medication room has been fixed.</p> <p>Sink, mirror and countertops have been cleaned.</p>	3/10/14

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F 465	<p>Continued From page 71</p> <p>somewhere else to shower (other than the D Wing) and hoped the facility would get the shower fixed sooner or later.</p> <p>On 1/30/14 beginning 12:21 p.m. Staff M reported all but two residents were transported in a shower chair covered with bath blankets and not all shower chairs had shower buckets. Staff M reported a resident episode of incontinence during transport required the resident to sit in the shower chair in a common hall covered only with a bath blanket for seven minutes while waiting for the floor to be cleaned before staff could finish transport to the A Wing shower.</p> <p>Staff M also reported Resident #20 stated he/she wanted the D Wing shower fixed so he/she didn't have to go so far to get showered.</p> <p>On 1/30/14 at 11:15 a.m., when asked how long the D wing shower did not function, Staff A reported he/she had plumbing records and provided a copy of a plumbing invoice requested. The invoice date indicated the facility had a plumbing company provide services on 5/22/13, more than eight months earlier. The invoice documented the bottle from the drain could not be removed and the "line may need to be dug up and repaired at problem area." Staff A also reported the facility did not have current plans to repair the shower.</p> <p>B WING SHOWER</p> <p>On 1/29/14 at 10:14 a.m. a cracked tile on the floor of the B Wing shower had water and bubbles coming out of cracks in the grout. Staff K reported the concern had been reported. Staff A came to look at water and bubbles in the cracked grout and reported he/she had never been</p>	F 465	<p>Paper towel dispenser and soap dispenser have been filled.</p> <p>Sharps container has been emptied.</p> <p>Drawers and cupboards have been provided handles.</p> <p>Housekeeping has updated task lists and scheduled cleaning of floors, shower rooms, med rooms, utility rooms and common areas in facility.</p> <p>Shower Rooms will be audited weekly as part of the preventative maintenance rounds to assure repairs are completed and area is clean.</p> <p>Shower Aides will be reeducated on using the maintenance logs to report needed repairs.</p> <p>Staff will be reeducated on using the maintenance logs to report needed repairs.</p> <p>Laundry room will be audited monthly as part of the preventative maintenance rounds</p>	3/10/14

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F 465	<p>Continued From page 72 informed.</p> <p>On 1/29/14 at 2:30 p.m. there was strong unpleasant odor in the same shower room on the B Wing. Staff Q, present, did not know the ceiling vent fan did not work and the room needed a new exhaust system. Staff Q also reported maintenance issues should be written on the maintenance log if broken.</p> <p>A WING SHOWER On 1/28/14 at 2:30 p.m. both shower drains in the A Wing shower were missing drain covers.</p> <p>On 1/30/14 beginning 12:22 p.m. Staff M reported the A Wing shower did not have a drain cover for a while. Staff A also stated she reported the problem with back up from one of the shower drains prior to the start of survey (1/21/14).</p> <p>On 1/29/14 at 2:30 p.m. Staff Q reported drains were put in place two weeks ago and had not been informed they were missing again.</p> <p>MISSING KEY TO C WING SHOWER On 1/29/14 at 3:12 p.m. the surveyor requested a copy of the key to the locked shower room on C Wing to look inside. Nursing staff could not locate the key.</p> <p>On 1/30/14 at 1:50 p.m. Resident #128 reported he/she used to shower on the C Wing on his/her own during the evening but nursing staff did not have a key on the pill cart to get into the room when he/she wanted. The resident also reported asking staff multiple times for the key after shower staff finished for the day and shower staff took the keys home with them.</p>	F 465	<p>to assure repairs are completed and area is clean.</p> <p>Laundry Staff will be reeducated on using the maintenance logs to report needed repairs.</p> <p>Progress and trends of audits will be reported during monthly QAPI meeting.</p> <p>Administrator or designee will be responsible to ensure correction</p>	3/10/14

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F 465	<p>Continued From page 73</p> <p>Later on 2/4/14 at 6:10 p.m. the surveyor asked for a copy of the C Wing shower key again to look inside. Evening Nursing Staff OO tried all keys on the C Wing medication cart and did not locate a key that could open the C Wing shower room door.</p> <p>Nursing staff did not have access to the C Wing shower key when Resident #128 wished to use it. The shower key was noted missing on 1/29/14. Staff did not have a copy available one week later on 2/4/14. Maintenance records did not identify staff reported they needed a key copy made.</p> <p>NURSING STATION C/D WING</p> <p>On 1/30/14 at 1:55 p.m. the sink inside the nursing station was covered with a black board and the faucet did not work. When opened, the lower cabinet door beneath the sink contained debris and had a large hole behind the cabinet wall that exposed pipes. An unpleasant odor emanated from inside the cabinet when cabinet doors were opened.</p> <p>An eye wash station on top of the counter to the right of the sink also did not function. Staff H reported the eye wash station worked. Staff H turned the knob to turn on the water and it did not work.</p> <p>Staff F also present, reported the sink had not worked for "months." When asked what sink staff used to wash their hands in, Staff F reported, they could use the medication room sink or the room across the hall or a resident room.</p> <p>The medication room required handling a set of medication keys and opening a doorknob. Not all nurses have access to these keys. If residents in</p>	F 465		3/10/14

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F 465	<p>Continued From page 74</p> <p>rooms desired privacy or slept staff would not be able to enter those rooms to wash hands either.</p> <p>When the surveyor attempted to open the door across the hall it required a digital key pad code. After multiple attempts to open the door two staff intervened. Staff OO attempted to open the door also and did not succeed. A second staff demonstrated how the handle of the door had to first be turned to the left before it could be turned to the right to open. The knob of the door felt loose when turned.</p> <p>LAUNDRY ROOM EYE WASH During observations in the laundry on 1/29/14 beginning 12:11 p.m. the surveyor attempted to turn on the eye wash station and it did not operate. Staff LL reported, it should work and attempted to operate it and no water came on. Staff LL reported he/she did not know it didn't work.</p> <p>On 12/5/14 the surveyor requested a copy of all maintenance logs for the past six months. The facility provided a copy of Maintenance Logs later at 12:15 p.m. dated between 8/21/12 through 12/22/13. Maintenance logs did not identify maintenance concerns for the cracked, leaking tile in the B Wing shower and broken ceiling vent fan; missing drain covers in the A Wing shower or the non-functioning sink in the C/D Wing nursing station.</p> <p>Without completed records identifying all maintenance concerns, the facility would not be able to determine if all issues were being addressed timely.</p> <p>MEDICATION ROOM ON C/D WING</p>	F 465		3/10/14

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F 465	<p>Continued From page 75</p> <p>1) Lighting concerns in the C/D Wing medication room</p> <p>On 1/29/14 at 3:53 p.m., during observation with Staff OO, the medication room was dimly lighted.</p> <p>The medication room had housings for four florescent light fixtures: two on the ceiling which were approximately three feet long, one over the sink approximately 18 inches long, and one under the cupboards over the counter approximately 14 inches long.</p> <p>There was only one functional light fixture in the medication room: the ceiling fixture on the left. The other ceiling fixture, and the fixtures over the counter and sink, had no shades/covers or light bulbs. A tall table lamp with no shade was sitting on the counter and was not plugged in. Staff OO said he/she had never seen the lamp turned on or plugged in.</p> <p>Another tall table lamp with no shade was sitting on the toilet room floor; the lamp was turned on and the door left open, which Staff OO said was to help illuminate the medication room.</p> <p>The ceiling light fixture in the toilet room had no cover or light bulb and the fixture base was loose, hanging by wires. Staff OO said the nonfunctional lights in the medication room and toilet room had been inoperable for several months. Staff OO said, in order to see well enough to perform tasks such as drawing up medications in a syringe or pouring liquids into a cup, he/she had to hold materials up close to the one functional ceiling light.</p> <p>A small refrigerator sitting on the counter, stocked</p>	F 465		3/10/14

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F 465	<p>Continued From page 76</p> <p>with insulin for residents on C and D wings, did not have a functional interior lamp. Staff OO agreed that insulin needed to be kept within a recommended temperature range and it was difficult to read the thermometer in the refrigerator without taking the thermometer out of the refrigerator.</p> <p>On 1/30/14 at 11:20 a.m., Staff Q said he/she received a work order for the nonfunctional lights in the C/D Wing medication room about four months ago but he/she had not figured out how to fix the lights without cutting power to the C/D wings.</p> <p>2) Other maintenance and housekeeping concerns in the C/D medication room</p> <p>On 1/29/14 at 3:53 p.m., during observation with Staff OO, the following concerns were identified:</p> <ul style="list-style-type: none"> -The white porcelain sink basin was covered with light brown residue. Much of the vanity countertop surrounding the sink was covered in light white/gray residue. Approximately 2/3 of the mirror above the sink was covered with white splatter marks. -The paper towel dispenser was empty; a stack of paper towels was lying on the vanity countertop approximately three inches from the sink. -The soap dispenser mounted over the sink vanity was empty. The soap dispenser refill cartridge was sitting on the vanity countertop. -The sharps container for discarding used syringes and needles, attached to the medication cart, was filled approximately two inches over the 	F 465		3/16/14

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F 465	Continued From page 77 fill limit line. -Drawers: Eight supply drawers had no handles; three drawer handles were hanging loose, attached by one screw. -Cupboards: Six supply cupboards had missing handles with sharp ends of screws protruding outward. On 1/30/14 at 10:56 a.m., during observation of the C/D Wing medication room with Staff B, all observations identified on 1/29/14 were unchanged. The facility failed to provide a comfortable and functional work environment for residents and staff. This had the potential to compromise dignity and quality of life for residents related to shower needs; for staff to not have a clean environment in which to store and prepare medications; and ready access to hand washing stations to prevent spread of infection and/or to delay treatment of eye injuries due to lack of immediate access to an eye wash station in the laundry.	F 465		3/10/14
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced	F 490	F490 Refer to F253 for immediate action taken. Administration has been provided additional training and coaching by Regional Director of Operation to assure that the administrator maintains compliance with regulation and to assure residents	

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F 490	<p>Continued From page 78</p> <p>by: Based on observations interview and record review, the facility's administration through its supervisory staff failed to ensure the facility effectively and efficiently attained, and/or maintained, each resident's optimal physical, mental and psychosocial well-being in the areas of housekeeping and maintenance. This failure created the potential for harm for residents and placed all residents at risk for unmet needs and decreased quality of life from ongoing unclean environmental conditions.</p> <p>Finding include:</p> <p>Refer to the following regulatory failure in F253 for observations, interviews and record reviews.</p> <p>Quality of Life</p> <p>F 253 Substandard level of care regarding failure to ensure housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable environment.</p> <p>The administrator is responsible for overall operation of the facility for compliance with regulations and to ensure residents received care and services that met their needs. The facility was at a substandard level with the a declining environment that impacted quality of life for all residents.</p>	F 490	<p>receive care and services that meet their needs.</p> <p>Regional Director of Operations will do regular facility visits and random audits of facility housekeeping and maintenance to assure administration compliance.</p> <p>Progress and trends of audits will be reported to administrator for monthly QAPI meeting.</p> <p>Administrator will maintain compliance with regulations and to that residents receive care and services that meet their needs to ensure correction.</p>	3/10/14

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