

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

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PRINTED: 04/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505280	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/04/2013
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NAME OF PROVIDER OR SUPPLIER RENTON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 80 SOUTHWEST SECOND STREET RENTON, WA 98057
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Federal Quality Indicator Survey conducted at Renton Nursing and Rehabilitation Center on 03/27/13, 03/28/13, 03/29/13, 04/01/13, 04/02/13 and 04/03/13. A sample of 24 residents was selected from a census of 77, which included the review of two discharged residents in addition to four supplemental residents.</p> <p>Survey team members included:  RN, MN  MSW  RN, BSN  MA, RD, CD</p> <p>The survey team is from: Department of Social and Health Services Aging and Adult Services Administration Residential Care Facilities Region 2, Unit F 20425 72nd Avenue South, Suite 400 Kent, Washington 98032-2388</p> <p>Telephone: (253) 234-6000 Fax: (253) 395-5070</p> <p><i>Bernoth Steep</i> 4/12/2013 Residential Care Services Date</p>	F 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Renton Nursing and Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p style="text-align: right;">RECEIVED APR 25 2013 DSHS/ADSA/RCS</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Lony Sandbeck</i>	TITLE <i>Administrator</i>	(X6) DATE 4/24/13
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 166 SS=D	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure resident grievances were promptly acted upon for one (#68) of two and one supplemental (#89) residents reviewed for missing property. This failure prevented residents from using their own property and had the potential to cause emotional distress. Facility staff failed to address concerns voiced by residents in five of six months of Resident Council Minutes reviewed which caused residents to feel unheard and disregarded.</p> <p>In addition the facility failed to address resident concerns regarding a roommate. This failure caused Resident #68 to experience dissatisfaction with her living arrangement and frustration at facility staffs failure to address the concern.</p> <p>Findings include:</p> <p>MISSING ITEMS RESIDENT #68 In an interview on 03/27/13 at 3:07 p.m. Resident #68 indicated she had missing personal items stating, "My bras are missing, I am missing a cardigan (Christmas) and a blue blanket." The resident indicated she told staff and, "well, they</p>	F 166	<p>F166</p> <p>Corrective Action/s for residents identified to have been affected:</p> <p>The family (POA) of resident #68 was notified again about the missing clothing and our willingness to reimburse for the replacement of the clothing. [The family declined to have us purchase the replacement clothing].</p> <p>The family (POA) of resident #89 was notified again about the missing clothing and our willingness to reimburse for the replacement of the clothing.</p> <p>Resident #68 was offered the opportunity to relocate to a different location in the building and she refused. The offer to relocate remains an alternative to the current situation. Resident #68 and Resident #10 have been room mates for 3+ years.</p> <p>Identification of residents with the potential to be affected:</p> <p>We will continue to solicit information from residents about</p>	5/6/13	

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F 166	<p>Continued From page 2</p> <p>did say they would look but nothing has come of it ..."</p> <p>Observation of the resident room revealed a sign over the resident's bed which identified the missing bras and cardigan missing since 01/16/13 but there was no resolution to the missing items</p> <p>In an interview on 03/29/13 at 10:06 a.m., Staff J (Social Services) stated, "Residents generally tell the aids then the aids will tell us (Social Services) what the missing item is." Staff J explained it was facility practice to fill out a missing item form with a description of the missing items and give one to laundry and one to the aides so staff can look for the missing item. Staff J stated, "A copy of the form gets posted in the residents room if the resident allows it . . . we fill out the grievance and concern form attached to it. We give it two weeks...we check in one week then in two weeks and if (the item is) still missing replace the item."</p> <p>In an interview on 04/01/13, at 12:09 p.m. when asked about Resident #68's missing items Staff J stated, "That's pending, we are still waiting on the family to replace the items." When asked how long the facility typically waits for this to happen, as two and a half months had elapsed since the items were identified as missing, Staff J stated, "We don't really have a protocol, but I look at it periodically." Staff J added, "Now that it's an issue today, I will probably call the family."</p> <p>Similar findings were identified for Resident #89, for whom staff identified a grievance regarding missing items on 01/18/13 which was still unresolved as of 04/01/13. Staff J stated, "We</p>	F 166	<p>missing or lost clothing, offering to search for clothing or to reimburse for replacement clothing.</p> <p>Room mate compatibility issues are addressed when identified. Change in room location is offered 1st to the resident expressing the issue. (Change is dependent on availability of alternative locations). Other remedies to enhance compatibility are offered to help mitigate compatibility issues such as head phones to mitigate loud TV issues.</p> <p>Measures to prevent recurrence:</p> <p>The Resident Council will be reminded that issues of lost or missing clothing need to be reported to Social Services and that "Grievance/Concern" forms are available by their door.</p> <p>Residents will be notified of the lost/missing clothing policy and the policy regarding room mate compatibility and request for relocation at the next Resident Council Meeting.</p> <p>Issues of lost or missing clothing, room mate compatibility and/or</p>		

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F 166	<p>Continued From page 3 brought it up at the care conference. The family was supposed to take care of it."</p> <p>RESIDENT COUNCIL CONCERNS A review was conducted of the Resident Council Minutes for 09/24/12, 10/29/12, 11/30/12, 01/28/13, 02/25/13 and 03/25/13. As documented in the Minutes, residents had issues concerning missing clothing for five of the six meetings (01/28/13, 03/25/13 11/30/12, 10/09/12, and 09/24/12). The handwritten Minutes for each meeting contain a form titled "Resident Council Response Form" which is intended for the facility to respond to the monthly identified concerns. For all six months reviewed, there were no responses from the facility concerning the missing clothes.</p> <p>On 04/01/13 at 1:45 p.m., an interview was conducted with Staff K, the facility Liaison to the Resident Council. When asked about the continued Council concerns about missing clothing, he stated it had been a long standing issue for the Council. When asked about the lack of documentation of facility's response to the concerns, he stated he usually didn't keep track of the individual resident names and therefore did not address them individually with Maintenance/Housekeeping.</p> <p>GRIEVANCES RESIDENT #68 In an interview on 03/27/13 Resident #68 stated, "I have issues with my roommate right now, she is suffering with partial [REDACTED] and she's very mean to me . . . like today, she opened the (privacy) curtain and looks at me and . . . she wanted to get somebody down here for her to go to bed because her back was bothering her, she</p>	F 166	<p>potential room changes are addressed at morning meeting with all department managers.</p> <p>Monitor for Corrective Action:</p> <p>Audits of Grievance/Concerns expressed by resident and/or, families (responsible party) will be done weekly by the Social Service Director. The log of Grievance / Concern issues and their resolution will be reviewed at the monthly Quality Assurance meeting.</p>		

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F 166	Continued From page 4 just starts yelling for somebody to come down to the room and I told her I said ring your buzzer instead of yelling which I have to tell her all the time . . . she yells and screams so loud." Resident #68 elaborated her roommates behaviors were disturbing and interfered with her ability to sleep, stating, "If we could get rid of her we'd be all right." In an interview on 03/27/2013 at 3:04 p.m. Resident #68 stated facility staff did not address this ongoing concern to her satisfaction. Resident #68 explained, "I've tried to get them to get her (roommate) to another room, they tell me I have to move 'cuz I am doing the complaining . . . I've been in this room four years . . . that's not right . . . her behaviors have gotten worse, she's terrible to live with . . . I would be happier without her as a roommate, but I am not moving so I just sit it out." In an interview on 04/02/13 Staff J (Social Worker) stated, "I know not too long ago when (the roommate) was yelling out at night we talked to Resident #68 to see if she wanted to move . . ." Staff J was requested to provide information regarding any attempts at resolving Resident #68's roommate concerns. On 04/3/13 at 11:48 a.m., Staff J (Social Services) indicated there was no evidence in the record to support staff addressed Resident #68's concerns and currently, "both residents want a room change" and Resident #68 was "fired up" about wanting to move.	F 166			
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES	F 242			

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F 242	<p>Continued From page 5</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to allow three (#108, 68 & 156) of three residents reviewed for choices and two residents (#s 90 and 134) interviewed in Stage 1, the right to make choices regarding important daily routines, including accommodating preferences for a tub bath and frequency of bathing. This failure placed residents at risk for a diminished quality of life and poor hygiene.</p> <p>Findings include:</p> <p>RESIDENT #68 According to the quarterly 01/16/13 Minimum Data Set (MDS) Resident #68 indicated it was "very important" to choose between a shower, tub or bed bath." In an interview on 03/27/2013 at 2:54 p.m. Resident #68 indicated she did not get to choose whether she took a shower, tub or bed bath stating, "we don't have tubs here...yeah I would take a bath."</p> <p>In an interview on 04/02/13 at 10:07 am Staff F (Licensed Nurse), indicated the facility had a whirlpool tub but, "We never use it, it's been a long time, we use the whirlpool room for storage now, the last time we used it was for someone</p>	F 242	<p>* *F242</p> <p>Corrective Action/s for residents identified to have been affected:</p> <p>Residents #108, #68, #156, #90 were interviewed regarding their bathing preferences. Their preferences were included on their care plan and resident care directives. Bathing schedule will be adapted to accommodate their preferences. Resident #134 was discharged.</p> <p>Identification of residents with the potential to be affected:</p> <p>Residents will be interview regarding their bathing preferences on admission and quarterly thereafter with their bathing preference documented on their care plan and resident care directives.</p> <p>Measures to prevent recurrence:</p> <p>Re-education regarding bathing preferences will provided the direct care staff.</p> <p>Quarterly care conferences will be audited to assure bathing preferences are being addressed.</p>	5/6/13
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F 242	<p>Continued From page 6</p> <p>with a wound, I don't know how long ago." In an interview on 04/02/13 at 10:10 am Staff H (Restorative Aide) stated, "it ' s been a while since we've used (the Arjo tub) I think like two years..."</p> <p>In an interview on 04/02/13 at 10:00 a.m., Staff F (Certified Nursing Assistant-CNA), indicated he had worked at the facility for over a year and stated, "we do have a whirlpool (tub) on (the back unit)...but I haven't given a bath, not since I've been here." Staff Q (CNA), in an interview stated she had worked in the facility for eight years but hadn't used the Arjo tub.</p> <p>In an interview on 04/01/13 at 11:28 a.m., Staff P (CNA) indicated she had worked at the facility for three months and "have never used the bathtub." In an interview on 04/03/13 at 10:40 a.m. Staff P was asked how to disinfect the whirlpool tub to which she replied, "We don't use it". In an interview on 04/01/13 at 11:10 a.m., Staff R revealed she had worked at the facility for a year, usually working on the front units. Staff R stated, "We don't have a bathtub in the front but we do in the back...no we don't use the bathtub...no I have never given a resident a tub bath we just give them a shower. Staff R reported, "I just ask them, "Today is your shower day would you like to take a shower? And sometimes they say yes and sometimes no."</p> <p>Observation of the whirlpool room on 04/02/13 at 10:10 a.m. revealed an Arjo bathtub with a leaky faucet and moderate amounts of dust on the interior tub surface. The whirlpool room was cluttered with multiple wheelchairs, a mechanical lift and a commode chair.</p>	F 242	<p>*Monitor for Corrective Action:</p> <p>RCMs will audit weekly shower/bathing schedule towards meeting resident preferences and the DNS or designee will assure compliance. The results of bathing audits will be reviewed at the monthly Quality Assurance meeting.</p>		

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F 242	Continued From page 7 In an interview on 04/03/13 at 11:00 a.m., Staff K, (Activity Director) indicated he assessed resident's personal preferences as part of the MDS assessment process. Staff K stated the current system didn't allow for a mechanism to communicate resident bathing preference to the staff members who actually provide the bathing. In an interview on 04/03/13 at 10:50 a.m., Staff D (Staff Development) indicated she inserviced staff on the use of the Arjo, but confirmed there was no process to ensure resident's assessed preferences for bathing were conveyed to nursing staff. RESIDENT #156 Resident #156 was recently admitted to the facility. Her most recent MDS of 03/12/13 showed she had complex medical conditions including _____, _____, _____, _____, required limited to extensive assistance with activities of daily living and choosing between taking a shower or tub bath was very important to her. In an interview with Resident #156 on 03/27/13 at 10:30 a.m., when asked whether she could choose to take a shower, tub, or bed bath she reported, "I'm given a shower, I don't know if I can have a bath." In a follow up interview on 04/03/13 at 9:45 a.m., when asked about her preferences of a shower or bath, she reported, "I would really like a bath for my RA (_____) I'm used to taking a bath once a week and someone told me there is a bath tub available." Resident #156 was offered showers on Sundays	F 242			

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F 242	Continued From page 8 and Thursday. The shower record showed she refused her showers 1 to 2 times each week resulting in less than one shower a week since her admission in early March. In an interview with the unit's Resident Care Manager, Staff C, on 04/01/13 at 10:15 a.m., she reported if a resident refused a shower the staff would approach again on the same day to see if they would allow the shower to be given. "Everybody gets 2 showers a week, so if they refuse on one day, they will get one later in the week." In an interview with Staff N, the nursing assistant assigned to the resident, on 04/02/13 at 1:45 p.m., she reported Resident #156 was very smart and if she refused once during the day, she would say, "I already told you no." and would refuse the offering of a shower later on the same day. "Yesterday was her shower day, but she was going out with her son and she refused to take a shower before she left." On 04/03/13 at 9:45 a.m., Staff C was asked about the availability of a bath for residents on her unit, she reported, "I don't think it works, I've never seen it be used; no one would have told her there was a bathtub." Similar findings were identified for Resident #108, 90 and 134 who verbalized preferences for tub baths but were not given tub baths as an option.	F 242			
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive	F 246			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505280	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/04/2013
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F 246	<p>Continued From page 9</p> <p>services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure two of two residents (Resident #s 59 and 100) whom the facility were aware smoked cigarettes, accommodated the resident's assessed need for an escort in order to physically smoke safely.</p> <p>Findings include:</p> <p>RESIDENT #59 Resident #59 was admitted to the facility approximately one month prior to the survey with diagnoses which included [REDACTED] and [REDACTED] ([REDACTED]). The resident's Initial Minimum Data Set assessment (MDS) dated 03/07/13, indicated the resident was cognitively intact scoring a 15 out of 15 on the Brief Interview of Mental Status (BIMS) assessment. She was assessed as independent in eating and for locomotion both on and off the facility's units.</p> <p>A facility generated "Smoking Assessment" was completed for Resident #59 on 03/04/13. The facility's team decided the resident was unsafe to smoke independently stating "Requires supervision. CVA (with [REDACTED]) [REDACTED] Staff may escort out to designated smoking area</p>	F 246	<p>F246</p> <p>Corrective Action/s for residents identified to have been affected:</p> <p>Resident #59 was discharged.</p> <p>Resident #100 was counseled regarding our smoking policy and a reasonable schedule was agreed to.</p> <p>Identification of residents with the potential to be affected:</p> <p>No other residents in the facility are identified as smokers.</p> <p>Measures to prevent recurrence:</p> <p>Re-education regarding our smoking policy will be provided to direct care staff.</p> <p>If a resident chooses to smoke after admission, they will be assessed for smoking safety to include the offering of a nicotine replacement patch and/or the need for staff supervision (escort) to smoke. If</p>	5/8/13	

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F 246	<p>Continued From page 10 as they are able."</p> <p>On 03/15/13 Resident #59 signed the "Resident Smoking Agreement" which indicated the resident would not smoke without an attendant and would not keep smoking materials on her person or in her room and would surrender all materials to the facility "for safekeeping." The facility developed a care plan dated 03/04/13 which reflected this agreement and contained an approach which included "She is cautioned and accepts that staff are available on a limited basis and that care is their primary focus."</p> <p>According to a "Notice of Transfer or Discharge" dated 04/01/13, at 12:30 a.m. on 04/01/13, Resident #59 was observed in an unauthorized area and smoking unescorted. According to the discharge notice, "It was reported and observed you were smoking in your semi - private room." The resident's behavior escalated over the incident to a loud discussion with the Licensed Nurse (LN) at the nursing station which disrupted other residents.</p> <p>The facility's investigation, according Staff B (Director of Nursing-DNS), determined Resident #59 was smoking outside on a deck/patio in an unauthorized area, not in her room as had been reported. Further, Resident #59 had been told by an LN she could not smoke after 10:00 p.m. because there was no staff available to escort her. Finally, the facility contacted the local police department to "reiterate our obligation to ensure the safety of all residents."</p> <p>RESIDENT #100 Resident #100 was last admitted to the facility in</p>	F 246	<p>direct supervision is deemed necessary, an escort will be provided at reasonable scheduled times.</p> <p>Monitor for Corrective Action:</p> <p>Resident smoking incidents, if identified, will be reviewed at morning clinical meeting with followup as appropriate to meet resident's smoking needs (including scheduled times) and overall resident safety.</p> <p>Audits of resident smoking incidents or resident's requests for smoking privileges will be reviewed monthly at the Quality Assurance meeting to assure consistent application of our smoking policy.</p>		

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F 246	<p>Continued From page 10 as they are able."</p> <p>On 03/15/13 Resident #59 signed the "Resident Smoking Agreement" which indicated the resident would not smoke without an attendant and would not keep smoking materials on her person or in her room and would surrender all materials to the facility "for safekeeping." The facility developed a care plan dated 03/04/13 which reflected this agreement and contained an approach which included "She is cautioned and accepts that staff are available on a limited basis and that care is their primary focus."</p> <p>According to a "Notice of Transfer or Discharge" dated 04/01/13, at 12:30 a.m. on 04/01/13, Resident #59 was observed in an unauthorized area and smoking unescorted. According to the discharge notice, "It was reported and observed you were smoking in your semi - private room." The resident's behavior escalated over the incident to a loud discussion with the Licensed Nurse (LN) at the nursing station which disrupted other residents.</p> <p>The facility's investigation, according Staff B (Director of Nursing-DNS), determined Resident #59 was smoking outside on a deck/patio in an unauthorized area, not in her room as had been reported. Further, Resident #59 had been told by an LN she could not smoke after 10:00 p.m. because there was no staff available to escort her. Finally, the facility contacted the local police department to "reiterate our obligation to ensure the safety of all residents."</p> <p>RESIDENT #100 Resident #100 was last admitted to the facility in</p>	F 246	<p>direct supervision is deemed necessary, an escort will be provided at reasonable scheduled times.</p> <p>Monitor for Corrective Action:</p> <p>Resident smoking incidents, if identified, will be reviewed at morning clinical meeting with followup as appropriate to meet resident's smoking needs (including scheduled times) and overall resident safety. The DNS or designee will assure proper identification of smoking situations and assessment if indicated.</p> <p>Audits of resident smoking incidents or resident's requests for smoking privileges will be reviewed monthly at the Quality Assurance meeting to assure consistent application of our smoking policy.</p>		

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F 246	<p>Continued From page 11</p> <p>3/12 with diagnoses including [redacted] and [redacted]. The resident's last quarterly MDS dated 03/07/13 indicated the resident was cognitively intact scoring a 14 out of 15 on the BIMS assessment. She was assessed as independent in eating and for locomotion both on and off the facility's unit.</p> <p>A facility generated "Smoking Assessment" was completed for Resident #100 on 02/22/13. The facility's team decided the resident was unsafe to smoke independently stating "Resident was explain (sic) to that she can't smoke in the court yard & that if she wants to smoke she must ask a care giver to take her to the Designated smoking area."</p> <p>On 02/22/13 Resident #100 signed the "Resident Smoking Agreement" which indicated the resident would not smoke without an attendant and would not keep smoking materials on her person or in her room and would surrender all materials to the facility "to be locked away." The facility developed a care plan dated 02/23/13, and updated 03/16/13, which reflected this agreement and contained an approach which included "She understands her right to smoke will be respected with her compliance with seeking staff to assist her to the designated smoking area."</p> <p>On 04/01/13 at approximately 11:30 a.m., Resident #100 was observed smoking, not accompanied by staff, in the staff parking lot close to the maintenance shed. She was interviewed upon returning to the facility. When asked where she had gotten her cigarette, she stated the staff didn't know she had them. When asked if she had been escorted by a staff person</p>	F 246			

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F 246	<p>Continued From page 12</p> <p>she indicated "No," stating "I know I'm not supposed to but it's hard to find anyone to smoke with me. They all say they're too busy taking care of people."</p> <p>FACILITY POLICY Review of the facility's "Smoking Policy" (last reviewed 02/13) stated the facility was to provide a safe environment by "limiting the use of smoking materials on its grounds." It further stated "Residents, who do not meet the established criteria for independence, will be provided assistance during a supervised smoking activity." The policy goes on to state "Staff is responsible for ensuring that smoking by residents is done in a safe manner . . . only as specified in their care plan per their smoking assessment."</p> <p>Interviews were conducted with Staff B (DNS) on 04/02/13 at 9:10 a.m., 12:25 p.m. and 2:15 p.m. She stated the facility was a non-smoking facility but permitted residents to smoke in the employee parking area near the maintenance shed in accordance with their plan of care. She stated she considered Resident #s 59 and 100 to be unsafe to smoke independently related to their hemiparesis and the physical location of the facility (presence of a transient population) and therefore required an escort to smoke.</p> <p>When asked if the facility had designated smoking times or staff stipulated to accompany the residents to smoke, Staff B stated "No. I can't subject my staff to second hand smoke unless they agree to it. It is the responsibility of the residents to find staff to escort them so long as it doesn't interfere with resident cares." When asked</p>	F 246			

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F 246	Continued From page 13 for clarification, Staff B stated "If they can't find someone to be with them, they can't smoke." The facility failed to provide reasonable accommodations of individual needs and preferences through failure to provide a means to support safe smoking for Residents #59 and 100, in accordance with their care plan and the facility's policies.	F 246	<p>*F250</p> <p>Corrective Action/s for residents identified to have been affected:</p> <p>Resident #68 was offered the opportunity to relocate to a different location in the building and she refused. The offer to relocate remains an alternative to the current situation. Resident #68 and Resident #10 have been room mates for 3+ years.</p> <p>For Resident #60, an interpreter fluent in Taishanese was retained to facilitate communication of needs. In addition, additional visual communication boards were obtained to facilitate communication of needs.</p> <p>Measures to prevent recurrence:</p> <p>Room mate compatibility issues are addressed when identified, including a review at the morning clinical meeting. A change in room location is offered 1st to the resident expressing the issue.</p> <p>Residents unable to communicate in English are reviewed on admit, quarterly, or with a change of</p>	5/8/13	
F 250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide medically related social services to meet the psychosocial needs of Resident #68 who experienced interaction difficulties with her roommate and for Resident #60 who required a alternative communication services related to her lack of English language skills. These failures resulted in both residents failing to reach their highest practicable well-being.</p> <p>Findings include:</p> <p>RESIDENT #68 Resident #68 was originally admitted to the facility [REDACTED] /09 with [REDACTED]</p>	F 250			

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F 250	<p>Continued From page 14</p> <p>conditions including [REDACTED] Her most recent quarterly Minimum Data Set (MDS) assessment dated 01/16/03 assessed the resident as mildly cognitively impaired scoring a 13 out of 15 on the Brief Interview of Mental Status (BIMS). The MDS assessed the resident as being totally dependent to requiring extensive assistance of one person for activities of daily living. The resident was totally dependent on staff for locomotion in the facility.</p> <p>During the Stage I interview conducted with the resident on 03/27/2013 at 3:04 p.m., in reply to the question "Do you have any concerns with your roommate" Resident #68 replied "I have issues with my roommate (Resident #10) right now . . . She's very mean to me . . . She yells and screams so loud, it interferes with my sleep." Resident #68 indicated this had been going on for "Quite a while."</p> <p>When asked if she had discussed her concerns with facility staff, Resident #68 replied "I've tried to get them to get her another room. They tell me I have to move 'cuz I'm doing the complaining . . . I've been in this room four years . . . Her behaviors have gotten worse. She's terrible to live with..."</p> <p>During this interview, Resident #68's roommate was noted to wake up yelling "Somebody's being killed," yelled out again loudly and then fell asleep. The behavior was very loud and significantly disrupted the interview.</p> <p>Review of Resident #10's mental health notes dated 12/21/12, "Per staff and (Resident #68), Resident #10 has begun yelling at staff, at</p>	F 250	<p>condition to assure that some method is available to facilitate communication of needs. Interventions such as interpreter and/or communication boards are provided if necessary.</p> <p>Social Services staff will be re-educated on e need to document in the social service notes all interactions they have with residents and to include any plans/resolutions to grievance/concerns.</p> <p>Monitor for Corrective Action:</p> <p>Resident communication abilities will be reviewed at least quarterly (or with a change in condition) to assure methods of communication are appropriate to identify needs.</p> <p>Resident room mate compatibility issues when identified are reviewed at morning clinical meeting to develop methods of intervention and resolution.</p> <p>Audits of communication limitations related to language other than English and our measures to accommodate will be conducted</p>	
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F 250	<p>Continued From page 15 (Resident #68) and during the night." There was no indication in the record facility staff addressed Resident #68 being yelled at by her roommate or evaluated the potential negative impact of having a roommate who yelled during the night.</p> <p>In a in interview on the morning of 4/03/13 social services Staff J confirmed staff did not address Resident #68's concerns and both Resident #68 and #10 now wanted a room change.</p> <p>RESIDENT #60 Resident #60 was admitted to the facility [REDACTED] 12 with [REDACTED] include [REDACTED]. Resident #60 did not have English as her primary language and both her Admission MDS dated 11/15/12 and her Quarterly MDS dated 02/04/13 indicated the resident required an interpreter to communicate with health care staff.</p> <p>In an interview on 04/01/13 at 9:18 a.m., social services Staff J stated, "Ours is more of a communication problem. She can be understood if there is an interpreter, but we couldn't get an interpreter at the time (of the MDS assessments)." She went on to state the facility had never independently contracted with an interpreter until the time of the survey, concluding "She can't really talk with anybody here . . . the language is getting in the way of her care."</p> <p>Staff J referenced a communication board. This board was a piece of paper with 13 phrases in the resident's native language matched with the same 13 phrases in English. This document was pinned above the resident's bed. However, the facility had failed to ensure the resident received</p>	F 250	<p>monthly and reviewed at the monthly Quality Assurance meeting.</p>	

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F 250	<p>Continued From page 15</p> <p>(Resident #68) and during the night." There was no indication in the record facility staff addressed Resident #68 being yelled at by her roommate or evaluated the potential negative impact of having a roommate who yelled during the night.</p> <p>In a in interview on the morning of 4/03/13 social services Staff J confirmed staff did not address Resident #68's concerns and both Resident #68 and #10 now wanted a room change.</p> <p>RESIDENT #60 Resident #60 was admitted to the facility [redacted]/12 with multiple medical diagnoses include [redacted]. Resident #60 did not have English as her primary language and both her Admission MDS dated 11/15/12 and her Quarterly MDS dated 02/04/13 indicated the resident required an interpreter to communicate with health care staff.</p> <p>In an interview on 04/01/13 at 9:18 a.m., social services Staff J stated, "Ours is more of a communication problem. She can be understood if there is an interpreter, but we couldn't get an interpreter at the time (of the MDS assessments)." She went on to state the facility had never independently contracted with an interpreter until the time of the survey, concluding "She can't really talk with anybody here . . . the language is getting in the way of her care."</p> <p>Staff J referenced a communication board. This board was a piece of paper with 13 phrases in the resident's native language matched with the same 13 phrases in English. This document was pinned above the resident's bed. However, the facility had failed to ensure the resident received</p>	F 250	<p>monthly and reviewed at the monthly Quality Assurance meeting.</p> <p>The Social Services Director will assure completion of admission or quarterly review of communication abilities.</p> <p>The DNS or designee will assure review of room mate compatibility grievances.</p>		

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F 250	Continued From page 16 evaluation and training in the use of the communication board or ensured it enabled the resident to communicate such basic needs as toileting through any other means. There was no effort on the part of the facility to attempt to improve Resident #60's communication abilities despite identified negative implications on the resident's care. Failure to make referrals and obtain services from outside agencies regarding interpreting services had the potential for Resident #60 to have unmet physical and emotional needs.	F 250	*		
F 253 SS=E	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, the facility failed to ensure the environment and resident care equipment was maintained in an orderly, clean and sanitary manner. Failure to identify and address observed problems in the resident environment placed residents at risk for injury or a diminished quality of life. Findings Include: Observation during initial rounds 03/27/13 revealed the sink in resident room 51 had a wheelchair accessible sink with paint chipped off and frayed wooden edges. Similar findings were	F 253	F253 Corrective Action/s for residents identified to have been affected: Wooden edges around sink were replaced. Replacement knee pads were ordered for the Sit-to-Stand equipment and will be installed when received. The drain cover in the shower room on Collectable Court Wing was replaced. The toilet seat in Room #26 was replaced and the plunger was removed from the Room. Armrests for the wheelchairs used by Residents #111, #146, #108, and #92 were replaced.	5/8/13	

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F 253	<p>Continued From page 17</p> <p>found for the resident sink in room 50 revealing one corner with a chipped edge.</p> <p>Also during initial rounds, the "Sit-to-Stand" lift on the Wild West Unit was observed to have a quarter sized area with white stuffing showing through on the left hand side.</p> <p>Observation of the shower room of the Collectible Court Unit revealed the drain cover was not attached. Observation throughout the survey revealed Room 26 had a white toilet seat which was worn through to the wood and an unbagged toilet plunger sitting on the edge of the bathtub.</p> <p>Additional observations during initial rounds on 03/27/13 revealed the wheelchair for Resident #111 had frayed edges to both the left and right arm rests with foam coming out of right arm rest.</p> <p>Similar findings were observed for the wheelchairs of Resident #146, #108 and #92. Failure to maintain these areas and items created surfaces which were not cleanable and could potentially cause damage to resident's skin.</p> <p>Observation of Resident #104's wheelchair 04/01/13 at 1:20 p.m. revealed she did not have an arm rest padding on the left side.</p> <p>Observation of the laundry room 04/02/13 at 11:00 a.m. revealed the drain cover on the ground in front of the dryers was broken in half, creating a hole where the drain cover was broken. A mop head was stuffed in place of the broken area to prevent staff from stepping in the hole. Additionally, the ceiling in the laundry room had water damage and an object was observed</p>	F 253	<p>The drain cover in front of the dryer in the laundry room was replaced.</p> <p>The ceiling in the laundry room was refinished to eliminate stains from water leak</p> <p>Identification of residents with the potential to be affected:</p> <p>NA</p> <p>Measures to prevent recurrence:</p> <p>Our preventive maintenance program will be reviewed (amended) to assure inclusion of wood trim condition around sinks and the condition of wheelchairs.</p> <p>Staff will be re-educated to report maintenance issues to the Maintenance Department.</p> <p>Monitor for Corrective Action: The preventive maintenance program will be reviewed at the quarterly Quality Assurance meeting to assure timely reporting of maintenance issues and repairs.</p>		

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F 253	Continued From page 18 to be showing through. Interviews with Staff M (Laundry) at this time and Staff L (Maintenance) 04/03/13 at 11:10 a.m., both staff acknowledged the drain was broken and stated a new drain cover had been ordered. Staff L in the same interview 04/03/13 stated "The leak (causing the ceiling damage) has been fixed," and indicated he would be fixing the ceiling next.	F 253	* F272 Corrective Action/s for residents identified to have been affected:	5/8/13
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures;	F 272	Resident #16 MDS was changed to reflect terminal diagnosis. Resident #42 discharged. Resident #157 discharged. Resident 37 MDS was modified to reflect terminal illness. Resident #162 MDS was modified to reflect terminal illness. Resident #46 was discharged and readmitted. Her assessment was updated to reflect urinary continence status. Resident #87 behavior plan was modified to eliminate the 1:1 supervision of behavior. *	

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F 272	<p>Continued From page 19 Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to accurately assess one (Residents #16) of one sample residents reviewed for end of life services and four (#42, #157, #37 and #162) supplemental residents. This failure could result in residents not receiving the care and services necessary. Additionally, the facility failed to ensure accurate assessments for Resident #46 (urinary incontinence), Resident #87 (behavioral and emotional status), #60 (cognitive patterns) and #84 (pressure ulcers). Failure to ensure accurate assessments detracted from staffs' ability to provide care which residents required.</p> <p>Findings include:</p> <p>URINARY INCONTINENCE RESIDENT #46 According to the Admission Minimum Data Set (MDS) dated 11/01/2012 the resident was assessed to be [REDACTED]. According to the Quarterly MDS dated 01/20/2013 the resident had declined in [REDACTED] and was now</p>	F 272	<p>Resident #60 was provided interpreter (Tsishanese). The resident was unable to communicate in her native language..</p> <p>Resident #84 was discharged</p> <p>Identification of residents with the potential to be affected:</p> <p>Initial and Quarterly assessments related to the Minimum Data Set (MDS) accuracy will be clinically reviewed. This will include all disciplines with MDS section input tasks.</p> <p>Measures to prevent recurrence:</p> <p>New and quarterly assessments will be reviewed to assure correlation with observed condition.</p> <p>Monitor for Corrective Action:</p> <p>RCMs will monitor accuracy of documentation and it relates to resident condition.</p> <p>DNS or designee will assure correlation of assessment with observed condition.</p>

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F 272	<p>Continued From page 19 Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to accurately assess one (Residents #16) of one sample residents reviewed for end of life services and four (#42, #157, #37 and #162) supplemental residents. This failure could result in residents not receiving the care and services necessary. Additionally, the facility failed to ensure accurate assessments for Resident #46 (urinary incontinence), Resident #87 (behavioral and emotional status), #60 (cognitive patterns) and #84 (pressure ulcers). Failure to ensure accurate assessments detracted from staffs' ability to provide care which residents required.</p> <p>Findings include:</p> <p>URINARY INCONTINENCE RESIDENT #46 According to the Admission Minimum Data Set (MDS) dated 11/01/2012 the resident was assessed to be continent of bladder. According to the Quarterly MDS dated 01/20/2013 the resident had declined in [REDACTED] and was now</p>	F 272	<p>Resident #60 was provided interpreter (Tsishanese). The resident was unable to communicate in her native language..</p> <p>Resident #84 was discharged</p> <p>Identification of residents with the potential to be affected:</p> <p>Initial and Quarterly assessments related to the Minimum Data Set (MDS) accuracy will be clinically reviewed. This will include all disciplines with MDS section input tasks.</p> <p>Measures to prevent recurrence:</p> <p>New and quarterly assessments will be reviewed to assure correlation with observed condition.</p> <p>Monitor for Corrective Action:</p> <p>DNS and RCMs will monitor accuracy of documentation and it relates to resident condition.</p>	
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F 272	<p>Continued From page 20 occasionally incontinent.</p> <p>In an interview on 04/01/13 at 8:49 a.m. Staff B (Director of Nursing-DNS) stated Resident #46 was recently discharged. Thus the resident was unavailable for observation or interview.</p> <p>Review of bladder incontinence evaluations, care plan documents, Activity of Daily Living (ADL) documents and nursing progress notes, there was no indication the resident was incontinent of bladder during the 01/20/13 MDS assessment period.</p> <p>According to the MDS coordinator, Staff I, "I gather my data from the assessment and staff and resident interview". In an interview on 04/02/13 at 9:02 a.m. Staff I, the MDS coordinator, stated, "my working papers indicated she was continent...It doesn't look like she had a decline (in urinary function)." Staff I confirmed the 01/20/13 MDS was coded incorrectly.</p> <p>BEHAVIORAL AND EMOTIONAL STATUS RESIDENT #87 Resident #87 was admitted to the facility on [REDACTED]/12 from her home where she had been living with family members. According to the resident's Quarterly MDS dated 03/18/13 indicated physically aggressive behaviors had occurred during the look back period for this assessment.</p> <p>Review of the facility incident reports revealed on 03/18/13 and 03/21/13, Resident #87 was found to have physically slapped two different residents on the face. According to the Incident Reports, both aggressions occurred at approximately 6:00</p>	F 272			

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F 272	<p>Continued From page 21</p> <p>p.m. and had involved Resident #87 passing in her wheelchair in close proximity to the other residents. The resident was not interviewable in relationship to the aggressive incidents because she did not remember the occurrences.</p> <p>Observations of Resident #87 occurred on all days of the survey and at random times. Each observation revealed the resident to be accompanied by a staff person at all times.</p> <p>Review of the medical record showed the "Resident's Behavioral Symptoms" Care Plan was amended on 03/22/13 to include "one-to-one" care with a behavior monitoring put in place for hitting. Review of the "Behavior Flow Sheet/PRN Psychotropic Medication Sheet" for both March and April 2013 showed no incidents of hitting after the 03/21/13 incident.</p> <p>An interview was conducted with social services Staff J at 9:45 a.m. on 04/02/13. She stated most of the time, Resident #87 had been pleasant, preferring not to interact much with other residents. She also stated "(Resident #87) always seemed kind of short tempered when we talked" but had not shown any physical aggression. When asked if possible causative factors for her hitting behaviors had been assessed prior to putting the one-to-one supervision on the resident, Staff J indicated possible sundowning had been considered but no observational assessment data had been collected to rule out this factor.</p> <p>Staff J stated the interdisciplinary team (IDT), consisting of her, Staff B and Staff C, did not assess other potential contributing factors such</p>	F 272			

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F 272	<p>Continued From page 22</p> <p>as the time of day, the close proximity of other residents, or the effect the physical environment might have had when considering possible interventions. She went on to state the facility was actively trying to discharge Resident #87 to a less restrictive environment because the IDT determined a calmer, more familiar and consistent environment would be "The best thing for her" but when asked, Staff J stated the IDT had not assessed how to incorporate this information into current facility interventions.</p> <p>An interview was conducted with Staff B (DNS) and C (Charge Nurse) on 04/02/13 at approximately 10:30 a.m. When asked if the IDT had assessed possible environmental or other contributory factors prior to initiating the one-to-one, both stated "No" because the behaviors were inconsistent and difficult to assess.</p> <p>The facility failed to assess possible causal factors for aggressive behaviors prior to initiating restrictive one-to-one supervision of Resident #87's resulting in the resident's isolation from normal personal interaction with her peers.</p> <p>COGNITIVE PATTERNS RESIDENT #60</p> <p>According to the 11/15/12 MDS the resident had clear speech and was understood and able to understand conversation, but required an interpreter to communicate with healthcare staff. However, another section of the MDS indicted an interview for mental status should not be completed because the resident was "rarely/never understood". Additionally staff documented the resident had both short and long</p>	F 272			

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F 272	<p>Continued From page 23</p> <p>term memory problems but staff documented the resident could recall four of four criteria used. In an interview with Staff J on 04/02/13, the resident could communicate, but no interpreter was used to conduct the interview for the MDS. Staff J indicated the resident could communicate her needs to staff and agreed the MDS was inconsistent in its coding. Staff B, in an interview on 04/02/13, was unable to explain how staff concluded the resident had a memory problem when no interpreter was used for the assessment.</p> <p>PRESSURE ULCERS RESIDENT #84 Resident #84 was initially admitted to the facility [REDACTED] 7/12 with multiple complex medical conditions including [REDACTED] with [REDACTED] [REDACTED] and a history of pressure ulcers on [REDACTED]. (Resident #84 was reviewed as a closed record.)</p> <p>The resident's Admission MDS dated 10/31/12 was the only completed assessment on the resident as a result of three hospital discharges and readmissions. This assessment indicated the resident was at risk for pressure ulcers, had moisture associated skin damage, and was prescribed a pressure reducing device for her chair/bed, nutritional intervention to manage skin problems and pressure ulcer care. The Care Area Assessments (CAAs) for nutrition and the "Review of Indicators of Pressure Ulcer(s)" were created. Under nutrition it states "She is taking mvi (multivitamins) to address healing needs of 2 stg (stage) II pressure ulcers." Under the</p>	F 272			

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F 272	<p>Continued From page 24 pressure ulcer area, it documents "2 blisters left hip."</p> <p>Review of nursing progress notes showed first indication of left hip pressure ulcer started as a blister on 10/30/12 during day shift; "Blister on her left hip/butt was noted. Turned to rt (right). side most of shift."</p> <p>A "Weekly Ulcer Measurement Tool" dated 11/01/12 was located indicating the pressure ulcer was a State II measuring 3 cm by 3 cm. A hand notation dated 11/26/12 on this same document indicates "Mechanical friction reclassify skin tear." The Tool dated 11/09/12 indicates a size of 8 cm by 5 cm, no depth noted with 100% granulation. The only other wound related assessment found in the medical record was a Weekly Skin Check dated 01/13 with no wound indicated.</p> <p>Interviews were conducted with administrative nursing Staff B on 04/02/13 at 2:10 p.m. and 04/03/13 at 10:15 a.m. She stated she had determined the wound was a skin tear; not a pressure ulcer. She stated she had received various training around the time of Resident #84's wound and based on this new knowledge, had reclassified the wounds from Stage II pressure ulcers to a skin tear. Staff B was asked to produce information she gathered which supported the reclassification and she stated she was unable to locate it.</p> <p>The facility failed to have consistent assessment and wound documentation for two wounds on Resident #84's [REDACTED] area which inconsistently called the wound in the majority of the facility</p>	F 272			

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F 272	<p>Continued From page 25</p> <p>documentation two Stage II pressures and the classification by Staff B as a "mechanical friction" or "skin tear."</p> <p>END OF LIFE/HOSPICE The MDS definitions for "Hospice Services" states: "Under the hospice program benefit regulations, a physician is required to document in the medical record a life expectancy of less than 6 months, so if a resident is on hospice the expectation is that the documentation is in the medical record."</p> <p>In an interview with Staff I, the MDS coordinator, on 04/02/13 at 1:30 p.m., she indicated she only marks End of Life/Terminal diagnosis on the Minimum Data Set (MDS) if it is documented in the chart by the physician the resident has six months or less to live. "I follow the MDS guidelines, I look for it to be specifically noted by the physician, I can't usually find it and don't mark it without the signed paperwork." Despite knowledge the resident met the criteria, with a life expectancy of less than six months, for hospice, facility staff failed to ensure MDS assessments reflected this.</p> <p>RESIDENT #42 This resident was evaluated for Hospice benefit services on 02/06/13 and placed on Hospice services on 02/07/13. The hospice paperwork stated, "This is to certify that the beneficiary, named below, is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course." A significant change MDS was completed on 02/06/13 due to her status change to receive Hospice services. Section J1400 Prognosis was marked "No" for</p>	F 272			

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F 272	Continued From page 26 the question "Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months?" RESIDENT #37 Resident #37 had received Hospice benefit services since 03/2012. The resident was recertified for services on 12/24/12 with the following note in the medical record, "Based on ARNP (Advanced Registered Nurse Practitioner) narrative he has a prognosis with life expectancy less than 6 months and qualifies for hospice services." This note was signed by the physician. The quarterly MDS was completed on 01/28/13 after the recertification for services was signed. and did not assess the resident as needing End of Life/Terminal care. Similar findings were identified for Residents #16, #157, and #162, who were enrolled in hospice in anticipation of death, but for whom staff failed to ensure the MDS reflected a terminal status.	F 272	*		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced	F 314	F314 Corrective Action/s for residents identified to have been affected: Resident #42 is discharged Resident #84 is discharged Identification of residents with the potential to be affected: Other residents with skin integrity issues were reviewed to assure that the documentation was consistent and complete: Using identical	5/6/13	

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F 314	<p>Continued From page 27</p> <p>by: Based on interview and record review the facility failed to ensure accurate and consistent assessments for two (Residents #42 and #84) of three residents reviewed for pressure ulcers. This failure placed the residents at risk to not receive the care and services needed for wound healing and prevention of further break down.</p> <p>Findings Include:</p> <p>RESIDENT #42 Resident #42 was admitted to the facility in [redacted] of 2012. She had multiple discharges and readmissions from October through her death in February 2013. Her 01/07/13 MDS (Minimum Data Set) reveled she had a complex medical history including a history of three [redacted] ([redacted]), chronic [redacted] [redacted] n, [redacted] and required extensive assistance of one to two staff members for her activities of daily living and had a Stage 2 pressure ulcer (partial thickness loss of skin).</p> <p>The "Treatments Flowsheet" for Resident #42 showed documentation for "Weekly skin checks, (-) to indicate no skin breakdown present and (+) for skin breakdown present." On 12/07/12 a (-) was marked; on 12/14, 12/21, and 12/28 a (+) was marked for each week.</p> <p>The corresponding "Weekly Skin Check" where the (+) was further described identified on 12/14/12 a "Pressure Ulcer: Excoriation on [redacted]" On the same "Weekly Skin Check" form the next box identified "Stage 2 @ [redacted]". There was not a date on this section, however</p>	F 314	<p>documents and assessment parameters in all reviews.</p> <p>Measures to prevent recurrence:</p> <p>Pressure Ulcer/Skin Grids and assessment tools will be standardized for all residents to provide consistent documentation of any identified skin integrity issue.</p> <p>Monitor for Corrective Action:</p> <p>DNS will monitor the consistency of forms and assessment definitions to assure comparative results are obtained.</p> <p>The DNS conducts and logs results of weekly skin assessments. DNS will conduct monthly skin integrity audits. The weekly logs monthly skin integrity audits are reviewed at the monthly Quality Assurance meeting to identify consistency of documentation and trends or patterns of skin condition.</p>		

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F 314	<p>Continued From page 28 corresponded with the skin check completed on 12/21/12.</p> <p>No documentation was located to identify what was meant by "Excoriation" or the size of the area identified on 12/14/12. A nursing treatment for "Desitin to excoriation in [redacted] q (every) shift" was started on that day. When the area became a Stage 2, treatment was not changed and the physician was not notified for appropriate treatment for the change in skin condition.</p> <p>Review of the resident's care plan for "Skin Impairment" was dated 10/12/12 and revised on 11/06/12. The care plan was not updated to reflect the resident's change in skin condition on 12/14 or on 12/21/12.</p> <p>The resident was discharged to the hospital on [redacted]/12 and readmitted on [redacted] 5/12. When the resident was readmitted a "Skin Grid for Pressure...Ulcers" was started with documentation of the condition of the Stage II pressure ulcer. The documentation noted this pressure areas was "Present on Admission" but failed to document or acknowledge the resident had the pressure area prior to discharge from the facility. The facility could not determine whether the pressure area had changed since discharge due to no documentation prior to discharge clearly assessing or identifying the condition and size of the area while in the facility.</p> <p>In an interview with Staff B (Director of Nursing-DNS) on 04/03/13 at 10:45 p.m., she reported the Skin assessment policy as "When a Stage 2 is identified, I do the skin book (Skin Grid for Pressure...Ulcers) and do a wound sheet and</p>	F 314			

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F 314	<p>Continued From page 29</p> <p>update the care plan." When asked about this resident in particular she reported, "We don't know anything about this (referring to the 12/14/12 notation) or if a viable assessment of the skin was done when it was identified as Stage 2. Excoriation means nothing, we need to know if it was blanchable or non-blanchable (reddened areas do not turn white when pressed with a finger), they should have defined excoriation. Treatment wasn't changed when it became a Stage 2, maybe it wasn't a Stage 2. I will agree it is an incomplete record." Staff B reviewed the chart and confirmed the care plan was not updated when the skin condition changed on 12/14/12 nor was a proper order obtained when the area was identified as a stage 2.</p> <p>RESIDENT #84 Resident #84 was initially admitted to the facility 7/12 with multiple complex medical conditions including [REDACTED] with [REDACTED] medication [REDACTED], [REDACTED], [REDACTED] ([REDACTED]) and a history of [REDACTED] on her [REDACTED]. From admission until her [REDACTED] in the facility on [REDACTED]/13, Resident #84 had three admissions to the facility after being discharged to the hospital. (Resident #84 was reviewed as a closed record.)</p> <p>The resident's Admission MDS dated 10/31/12 was the only assessment completed on the resident as a result of her multiple hospital discharges. This assessment indicated the resident was at risk for pressure ulcers, had moisture associated skin damage, and was prescribed a pressure reducing device for her chair/bed, nutritional intervention to manage skin</p>	F 314			

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F 314	<p>Continued From page 30</p> <p>problems and pressure ulcer care. The Care Area Assessments (CAAs) for nutrition and the "Review of Indicators of Pressure Ulcer(s)" were created. Under nutrition it states "She is taking mvi (multivitamin) to address healing needs of 2 stg (stage) II pressure ulcers." Under the pressure ulcer area, it documents "2 blisters [REDACTED]"</p> <p>Review of nursing progress notes showed first indication of [REDACTED] pressure ulcer started as a blister on 10/30/12 during day shift; "Blister on her left hip/butt was noted." A "Weekly Ulcer Measurement Tool" dated 11/01/12 was located indicating the pressure ulcer was a Stage II measuring 3 cm by 3 cm. with 100% granulation in the wound bed. The Tool dated 11/09/12 indicates a size of 8 cm by 5 cm, no depth noted with 100% granulation. A hand notation dated 11/26/12 on this same document indicates "Mechanical friction reclassify skin tear." The only other wound related assessment found in the medical record was a Weekly Skin Check dated 01/13 with no wound indicated.</p> <p>The plan of care for nutrition dated 11/01/13 indicates Stage II pressure ulcer on left hip. Skin integrity plan also reflected two Stage II pressure ulcers. The resident was care planned for a pressure reduction mattress and a pillow in her wheelchair. She also was to be turned every two hours. However, both of these care plans have been crossed out with the notation "Reclassification."</p> <p>Interviews were conducted with Staff B (DNS) on 04/02/13 at 2:10 p.m. and 04/03/13 at 10:15 a.m. She stated she had looked through the closed</p>	F 314			

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F 314	Continued From page 31 record and had determined the wound was a skin tear; not a pressure ulcer. She stated she had received various training around the time of Resident #84's wound and based on this new knowledge, had reclassified the wounds from Stage II pressure ulcers to a skin tear. Staff B was asked to produce information she gathered which supported the reclassification of a pressure ulcer to a skin tear and she stated she was unable to locate it. The facility failed to have consistent assessment, care planning and wound documentation for two wounds on Resident #84's [redacted] area which inconsistently called the wound in the majority of the facility documentation two Stage II pressures and the classification by Staff B as a "mechanical friction" or "skin tear."	F 314	*		
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 one of one	F 315	F315 Corrective Action/s for residents identified to have been affected: Resident #60 was provided interpreter (Taishanese). The resident was unable to communicate in her native language. Her current level of urinary function was assessed and bladder assessment with subsequent care planning has been implemented. Identification of residents with the potential to be affected: Other residents with communication limitations and issues of urinary continence were not identified. Measures to prevent recurrence:	5/8/13	

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F 315	<p>Continued From page 32</p> <p>residents (#60) reviewed for decline in urinary function received accurate assessment and appropriate treatment and services to restore as much normal bladder function as possible which placed the resident at risk for further decline.</p> <p>Findings include:</p> <p>Refer to CFR 483.20(b)(iii), F-272, Comprehensive Assessment CFR 483.15(g)(1), F-250, Social Services</p> <p>RESIDENT #60 According to the Admission Minimum Data Set (MDS) assessment dated 11/15/12, the resident was assessed as always continent of bladder and needed an interpreter to communicate with a doctor or health care staff. According to the 02/04/13 quarterly MDS, the resident was "occasionally incontinent" of bladder, had no behavioral issues and no dementia diagnosis.</p> <p>Observation on 04/01/13 at 7:15 a.m., revealed the resident lying in bed awake. The resident was noted to smile and say something in a foreign language. When asked her if she had to go to the bathroom the resident smiled and said, "Sorry" and "Thank you."</p> <p>Admission assessment documents dated 11/08/12 indicated the resident was alert to person and had no obvious problem with cognition. Staff identified difficulty with speech related to "Only speaks (a language other than English)". A bowel and bladder assessment dated 11/08/12 indicated the resident was alert and "continent of (bowel and bladder) takes self to toilet." A form labeled "Determining type of urinary</p>	F 315	<p>Resident unable to communicate in English will be reviewed to assure that some method is available to facilitate communication of needs; including issues of urinary incontinence. Interventions such as interpreter and/or communication boards will be provided if necessary.</p> <p>Monitor for Corrective Action:</p> <p>DNS will monitor assessments of urinary continence and the appropriateness of treatment and/or services.</p>		

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F 315	<p>Continued From page 33</p> <p>incontinence" was completed on 11/08/12 and indicated the resident had no incontinence.</p> <p>A bladder incontinence evaluation dated 03/09/13 indicated the resident was confused and disoriented, had no perception of need to void, no apparent voiding pattern and daily incontinence of bladder. Staff documented the resident had complete relief after voiding and had environmental factors which restricted toileting ability including "distance to toilet." However, there was no evidence facility staff identified interventions which might assist the resident in overcoming this environmental factor.</p> <p>According to this 03/09/13 bladder evaluation, staff determined the resident was unable to participate in a bladder program because she was "uncooperative/demented" which conflicted with the 02/04/13 MDS.</p> <p>Observations on 03/29/13, 04/01/13, 04/02/13 and 04/03/13 revealed the resident was calm and cooperative with care. The resident demonstrated no evidence of confusion or disorientation.</p> <p>In an interview on 04/01/13 at 8:55 a.m., Staff I, the MDS coordinator stated, "I think she speaks a foreign language and needs an interpreter." When asked how staff could communicate with the resident, Staff I stated, "nursing and social service would do a communication board, I think there is one in her Medication Administration Record (MAR)." Review of the MARs revealed a piece of paper labeled, "communication board" which had 13 items addressing issues including: "I am hungry, thirsty, hot, cold, sad, bored, nausea . . ." but nothing regarding toileting. When</p>	F 315			

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F 315	<p>Continued From page 34</p> <p>asked what staff do in the event of a decline in urinary status, Staff I indicated the resident should be evaluated for a bladder retraining program.</p> <p>Every half hour observations on 04/01/13 from 9:20 to 1:20 p.m., a period of four hours, revealed the resident was not toileted. According to the resident's care plan, staff were to toilet the resident every two hours. Failure to provide a consistent toileting schedule contributed to the resident's inability to remain continent.</p> <p>In an interview on 04/01/13 at 1:25 p.m., Staff P, a Certified Nursing Assistant caring for the resident, stated she toileted the resident, "After breakfast (at 9:10 a.m.), before (I put her in) bed, then after lunch (1:20 p.m.). She is pretty cooperative. She does assist. She holds to the rails on the toilet and assist with the gait belt; she is pretty quiet, she says 'thank you, thank you' . . . She doesn't ask to go to the bathroom but she can point to the bathroom."</p> <p>In an interview on the morning of 04/02/13, Staff B (Director ofr Nursing- DNS)questioned the accuracy of the 03/09/13 bladder assessment given there was no interpreter used to question the resident about bladder function and staff had no clear means of establishing confusion. Staff I, on 04/01/13 at 9:18 a.m., stated, "She can be understood if there is an interpreter."</p> <p>Failure to: accurately assess bladder function; correctly identify barriers; attempt a bladder retraining program; and implement care plans for every two hour toileting; placed the resident at risk for further decline in urinary function.</p>	F 315		
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F 315	Continued From page 35	F 315			
F 319 SS=D	<p>483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure one of one residents (Resident #87) who had been placed on one to one supervision for aggressive behaviors received the necessary care and services to assist her to reach and maintain the highest level of mental and psychosocial functioning using the less restrictive options.</p> <p>Findings include: Resident #87 was admitted to the facility on [REDACTED]/12 from her home where she had been living with family members. She was admitted with multiple medical diagnoses including [REDACTED], [REDACTED] and [REDACTED].</p> <p>According to the resident's Initial Minimum Data Set Assessment (MDS) dated 12/31/12, the resident did not show any physical behavioral symptoms directed toward others, such as hitting, during the look back period of the assessment. However, Resident #87's Quarterly MDS dated 03/18/13 indicated physically aggressive</p>	F 319	<p>*</p> <p>F319</p> <p>Corrective Action/s for residents identified to have been affected:</p> <p>Resident #87 was discharged on April 22nd to a less restrictive environment.</p> <p>Identification of residents with the potential to be affected:</p> <p>No other residents have 1:1 supervision of behaviors.</p> <p>Measures to prevent recurrence:</p> <p>Resident exhibiting behaviors that are abusive to other resident will be assessed to identify the minimal amount of intervention necessary to protect resident.</p> <p>Monitor for Corrective Action:</p> <p>Intervention to abusive behavior will be monitored for both effectiveness</p>	5/8/13	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505280	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/04/2013
NAME OF PROVIDER OR SUPPLIER RENTON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 80 SOUTHWEST SECOND STREET RENTON, WA 98057		
(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 319	<p>Continued From page 36 behaviors had occurred during the look back period for this assessment.</p> <p>Review of the facility incident reports revealed on 03/18/13 and 03/21/13, Resident #87 was found to have physically slapped two different residents on the face. According to the Incident Reports, both aggressions occurred at approximately 6:00 p.m. and had involved Resident #87 passing in her wheelchair in close proximity to the other residents. Resident #87 stated during both facility investigations she did not remember the slapping incidents and she felt safe in the facility.</p> <p>Observations of Resident #87 occurred on all days of the survey and at random times. Each observation revealed the resident to be accompanied by a staff person at all times. Most observations revealed the resident in her room with the staff person but the resident was also observed going to the dining room and being wheeled about the facility in her wheelchair. Interviews with two nursing assistants (CNAs), Staff T and Staff U, were conducted concerning the resident's behavior while they had provided one-to-one care. Both CNAs indicated the resident had no behaviors while they had been with Resident #87.</p> <p>Review of the medical record showed the "Resident's Behavioral Symptoms" care plan was amended on 03/22/13 to include "one-to-one" care with a behavior monitoring put in place for hitting. Review of the "Behavior Flow Sheet/PRN Psychotropic Medication Sheet" for both March and April 2013 showed no incidents of hitting during this time.</p>	F 319	<p>and appropriateness of the supervision level – initiating the least restrictive interventions first. This will be reviewed at the Clinical Meeting – that includes Social Services and Nursing managers.</p>		

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F 319	<p>Continued From page 37</p> <p>An interview was conducted with social services Staff J at 9:45 a.m. on 04/02/13. She stated most of the time, Resident #87 had been pleasant, preferring not to interact much with other residents. She also stated "(Resident #87) always seemed kind of short tempered when we talked" but had not shown any propensity to physical aggression. When asked if possible causative factors had been reviewed prior to putting the one-to-one supervision on the resident, Staff J indicated possible sundowning had been considered but no observational data had been collected to rule out this factor.</p> <p>Staff J stated the interdisciplinary team (IDT), consisting of her, Staff B and Staff C, did not examine other potential contributing factors such as the time of day or the close proximity of other residents when considering possible interventions. She went on to state the facility was actively trying to discharge Resident #87 to an Adult Family Home because the IDT determined a calmer, more familiar and consistent environment would be the best thing for her.</p> <p>An interview was conducted with administrative nursing Staff B and C on 04/02/13 at approximately 10:30 a.m. When asked if the IDT had considered possible environmental or other contributory factors prior to initiating the one-to-one, both stated "No" because the behaviors were inconsistent and difficult to assess. When asked if other less intrusive interventions to one-to-one had been attempted, both stated "No."</p> <p>The facility failed to determine causal factors for</p>	F 319			

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F 319	Continued From page 38 aggressive behaviors and failed to establish less intrusive/restrictive alternatives to Resident #87's physical aggression and inability to control her behaviors.	F 319	*	
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 the facility failed to ensure falls were thoroughly reviewed to identify fall risks and implement interventions to prevent accidents for one (Resident #60) of three residents reviewed with accidents. This failure placed Resident #60 at risk for repeated falls with injury. Findings included RESIDENT #60 Resident #60 was admitted to the facility on [REDACTED]/13 with diagnoses including [REDACTED], [REDACTED], [REDACTED] and [REDACTED]. According to the 11/15/13 Minimum Data Set (MDS), staff were unable to determine if the resident had experienced a fall in the month prior to admission.	F 323	F323 Corrective Action/s for residents identified to have been affected: For Resident #60, an interpreter fluent in Taishanese was retained to facilitate communication of needs. In addition, additional visual communication boards were obtained to facilitate communication of needs. Resident has had no falls after the fall identified on March 4, 2013. Identification of residents with the potential to be affected: NA Measures to prevent recurrence: All licensed staff will be re-educated regarding the completion of incident	5/8/13

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F 323	<p>Continued From page 39</p> <p>In an interview on 03/27/2013 10:50 a.m. Staff B (Director of Nursing-DNS) indicated Resident #60 had a fall in the last 30 days. Staff B stated, "She had a fall in her room. She speaks (a language other than English) . . . she can communicate but not much."</p> <p>According to the "At risk for falls r/t (related to) weakness Care Plan (CP), "The resident had a non-injury fall on 03/04/13." The goals included the following: "Resident will not have avoidable falls that result in falls", "Monitor for adverse side effects with medications which may contribute to fall (resident on multiple [REDACTED];" and "Orthostatic BP (Blood Pressure)(a method of checking for low BP in which symptoms of dizziness, faintness or lightheadedness appear on standing, and which are caused by low blood pressure) with falls as indicated."</p> <p>Review of a facility incident report dated 11/16/12 at 6:00 a.m. indicated, "Found resident sitting on floor no injury noted. . ." While staff identified the resident's temperature was 99 degrees and the BP was 160/82, there were no orthostatic BPs to rule out medication as a potential contributing factor to the fall.</p> <p>The investigation concluded no abuse or neglect occurred, however, there was no documentation of poential causal factors to the fall such as: assessment of where the resident's walker was, the type of footwear utilized at the time of the incident, when the resident was last toileted or last seen by staff, or what the resident was doing at the time of the fall.</p> <p>In an interview on 04/3/13 at 9:55 a.m., Staff B</p>	F 323	<p>reports to include orthostatic blood pressures on all falls and to identify and address all causal factors such as trip hazards, foot ware et al.</p> <p>Monitor for Corrective Action:</p> <p>The DNS or designee will assure the completion of incident reports and the Administrator will monitor completion.</p> <p>The completion of incident reports will be reported to the Quality Assurance committee to identify any practices that limit our ability to assess cause/effect relationships.</p>	

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F 323	<p>Continued From page 40</p> <p>(DNS) confirmed these issues should be addressed to identify patterns and applicable interventions to prevent recurrence.</p> <p>Review of another incident document dated 03/04/13 at 1:45 p.m. revealed, "Resident found sitting on floor next to unlocked wheelchair inside her room, denies hitting head." This form indicated the resident was last checked at 1:00 p.m. and to prevent recurrence staff were to perform, "visual checks during rounds." The investigation asked the question, "Was resident wearing proper footwear?" to which staff answered "No. Resident was wearing slippers." Facility staff indicated the resident had not received any medications within the last 8 hours, but review of the Medication Administration Record revealed the resident received the medications felodipine (side effects [SE] including dizziness), losartan and metoprolol (both with SEs of dizziness and low BP). In addition, there was no indication staff considered if the inappropriate footwear or the unlocked wheelchair possibly contributed to the fall.</p> <p>In an interview on 04/3/13 at 9:55 a.m., Staff B was unable to say where in the residents room (near the bed or bathroom) the fall occurred which might help staff understand if the resident was attempting to self-transfer to bed or meet toileting needs.</p> <p>Failure to ascertain factors contributing to the fall detracted from staff's ability to identify hazards and risks and implement appropriate interventions to prevent future accidents.</p>	F 323			
F 328	483.25(k) TREATMENT/CARE FOR SPECIAL	F 328			

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F 328 SS=D	<p>Continued From page 41 NEEDS</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure two of two residents (#166 and #104) reviewed for specialized intravenous services received proper treatment and care as ordered by the resident's physicians. These failures put the residents at risk for their Central Venous Catheters (CVC) to not function properly.</p> <p>Findings include:</p> <p>RESIDENT #166 According to the [REDACTED] order form dated 3/08/13 Resident #166 had a tunneled valved CVC device. Staff also documented on the same form the resident required flushing for a non-valved device. Resident observation on 04/02/2013 at 7:20 a.m. revealed the resident actually had an implanted device in the chest wall with clamps (non-valved). In an interview during</p>	F 328	<p>*F328</p> <p>Corrective Action/s for residents identified to have been affected:</p> <p>Resident #104 IV was discontinued</p> <p>Resident #166 IV treatment will be accurately identified in the Medication Administration Record (MAR) including appropriate MD order for flushing of IV access port.</p> <p>Identification of residents with the potential to be affected:</p> <p>No other resident have IV treatments.</p> <p>Measures to prevent recurrence:</p> <p>Licensed staff will obtain physician orders for all implanted ports and IV access.</p> <p>All residents with IV orders will be reviewed at morning clinical meeting to assure that physician orders are properly implemented.</p> <p>All heparin/normal saline flush orders will be appropriately</p>	5/8/13

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F 328	<p>Continued From page 42</p> <p>this same observation Staff D stated for this resident "That (IV order form) should indicate the device is an implanted non-valved port." Directions on this form clearly directed staff for "Implanted ports use [redacted] 100 u/ml" (u: units, ml: milliliters, [redacted] is an anticoagulant to prevent blood clots). However, review of the Medication Administration Record (MAR) did not reveal anything directing staff when, how much, or what type of fluid agent to use to flush this specialized device.</p> <p>Observation of the residents medication cart on 04/01/2013 at 2:30 p.m. revealed no Heparin for Resident #166 with which staff might flush the implanted port. Similar observations were made for the treatment cart. A thorough search of the medication room with Staff D revealed no Heparin had been dispensed from the pharmacy for the purpose of flushing Resident #166's implanted port.</p> <p>In an interview on 04/02/2013 at 6:50 a.m., Staff D confirmed the pharmacy sent 10 u/ml [redacted] and the resident had not received the 100 u/ml [redacted].</p> <p>Failure to ensure physician orders/protocols for implanted ports were accurately completed and/or transcribed to the MAR resulted in staff using the incorrect medication amount and placed the resident at risk for developing a blood clot inside the [redacted]. This could contribute to blood clots or an unusable CVC which would cause the resident to be unable to receive intended medications without enduring additional procedures to place a new CVC.</p>	F 328	<p>transcribed onto the MAR according to physician orders.</p> <p>Licensed staff will be re-educated on IV therapy flushes, access sites as well as implanted ports.</p> <p>Monitor for Corrective Action:</p> <p>The DNS or designee will monitor all IV orders and the transcription of order onto the Medication Administration Record and the provision of care.</p>		

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F 328	<p>Continued From page 43</p> <p>RESIDENT #104 Staff E on 04/01/2013 at 7:45 a.m. was observed to withdraw blood into the extension tubing of Resident 104's Peripherally Inserted Central (PICC) line. She then flushed the line with 8 mls (milliliters) of Normal Saline (NS) prior to the infusion of an antibiotic. After the infusion of the antibiotic, Staff E then flushed the PICC line with 5 ml of NS.</p> <p>In an interview 04/01/2013 at 9:19 a.m., Staff C (RCM) stated staff "Should not get blood return unless they are drawing blood." Review of the facility protocol for their venous access device maintenance also revealed there were no instructions to get blood return prior to a medication infusion.</p> <p>Record review revealed no information about what type of PICC line this resident had. The record did reveal she had an allergy to (an anticoagulant used to prevent blood clots). In the same interview on 04/01/2013 with Staff C, she agreed no information was in the chart and for this resident and the flushing orders for a non-valved should be followed. These orders stated to flush the with 5 ml of NS before the medication and with 5 ml of NS after the medication. Additionally, the instructions call for 3 ml of 10u/ml (u: units), which Staff C indicated would not be used due to the resident's allergy to</p> <p>In an interview 04/01/2013 2:00 p.m., Staff D (Staff Development) was asked how staff was supposed to know what kind of PICC line a resident had and therefore what flushing orders to follow. Staff D stated "They (order forms) are</p>	F 328	<p>RECEIVED APR 12 2013 DORIS/BLANKENHORN</p>	

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F 328	Continued From page 44 usually in there (the chart) . . . Then the amounts to flush with should be in the MAR" (Medication Administration Record). Review of resident's chart with Staff D revealed the proper order forms were not there. Additionally the MAR stated "Flush IV line before and after medication with NS." Staff D acknowledged this was not complete and stated "It should say specifically how much should be given." Additionally, since no orders pertaining to the PICC line were present in the chart there was also no direction to staff how to treat the line if Heparin could not be used. The failure to not have proper order forms with specific instructions resulted in improper treatment and care with staff initiating blood return when not indicated and infusing an improper amount of NS. This put the resident at risk for blood clots and a dysfunctional PICC line which would result in a delay in treatment.	F 328	* F332 Corrective Action/s for residents identified to have been affected: Resident #104 IV was discontinued. Resident #1 enteral nutrition MAR was updated to reflect the time the enteral nutrition is off with medication administration. Identification of residents with the potential to be affected: No other resident have IV therapy.	5/8/13	
F 332 SS=D	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, the facility failed to ensure a medication error rate of less than 5%. Two of four Licensed Nurses (Staff F and E) observed during medication pass failed to follow physician's orders	F 332			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505280	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/04/2013
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NAME OF PROVIDER OR SUPPLIER RENTON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 80 SOUTHWEST SECOND STREET RENTON, WA 98057
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F 332	<p>Continued From page 45</p> <p>and/or facility protocols which resulted in two of 25 medications being administered incorrectly. This resulted in a medication error rate of 8% with two (#104 and #1) of 11 residents reviewed experiencing medication errors. These failures placed residents at risk for decreased therapeutic effects of medications and complications related to specialized intravenous lines.</p> <p>Findings include:</p> <p>RESIDENT #104 Observation of medication administration 04/01/2013 at 7:45 a.m. revealed Staff E prepared Resident #104's Peripherally Inserted Central (PICC) line for the infusion of an antibiotic. Staff E was observed to flush the line with 8 mls (milliliters) of Normal Saline (NS). After the infusion of the antibiotic, Staff E then flushed the PICC line with 5ml of NS.</p> <p>Record review revealed no information about what type of PICC line this resident had or any clear direction to staff as to how much and which flushing agent to use. In the same interview on 04/01/2013 with Staff C, she agreed no information was in the record for flushing the PICC line, and for this resident, the flushing orders for a non-valved catheter should be followed. These orders directed staff to flush the catheter with 5ml of NS before the medication and with 5ml of NS after the medication.</p> <p>In an interview 04/01/2013 2:00 p.m. Staff D (Staff Development), she was asked how staff was supposed to know what kind of PICC line a resident had and therefore what flushing orders to follow. Staff D stated "They (the order forms) are</p>	F 332	<p>6:00a to assure being given on empty stomach</p> <p>Measures to prevent recurrence:</p> <p>Enteral nutrition policies will be inserviced with licensed staff by the Staff Development Coordinator and the Pharmacy Consultant to assure ongoing compliance with physician orders.</p> <p>Ongoing clinical competencies by the Staff Development Coordinator for medication administration will be initiated to assure competency and to identify areas of medication administration needing re-education.</p> <p>Monitor for Corrective Action:</p> <p>DNS or designee will monitor results of clinical competencies related to medication administration and the need for additional education related to Medication Administration.</p>	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 332	<p>Continued From page 45</p> <p>and/or facility protocols which resulted in two of 25 medications being administered incorrectly. This resulted in a medication error rate of 8% with two (#104 and #1) of 11 residents reviewed experiencing medication errors. These failures placed residents at risk for decreased therapeutic effects of medications and complications related to specialized intravenous lines.</p> <p>Findings include:</p> <p>RESIDENT #104 Observation of medication administration 04/01/2013 at 7:45 a.m. revealed Staff E prepared Resident #104's Peripherally Inserted Central () line for the infusion of an antibiotic. Staff E was observed to flush the line with 8 mls (milliliters) of Normal Saline (NS). After the infusion of the antibiotic, Staff E then flushed the PICC line with 5ml of NS.</p> <p>Record review revealed no information about what type of PICC line this resident had or any clear direction to staff as to how much and which flushing agent to use. In the same interview on 04/01/2013 with Staff C, she agreed no information was in the record for flushing the PICC line, and for this resident, the flushing orders for a non-valved catheter should be followed. These orders directed staff to flush the catheter with 5ml of NS before the medication and with 5ml of NS after the medication.</p> <p>In an interview 04/01/2013 2:00 p.m. Staff D (Staff Development), she was asked how staff was supposed to know what kind of PICC line a resident had and therefore what flushing orders to follow. Staff D stated "They (the order forms) are</p>	F 332	<p>Resident with Proton Pump Inhibitors (PPI) will be retimed to 6:00a to assure being given on empty stomach</p> <p>Measures to prevent recurrence:</p> <p>Enteral nutrition policies will be inserviced with licensed staff by the Staff Development Coordinator and the Pharmacy Consultant to assure ongoing compliance with physician orders.</p> <p>Ongoing clinical competencies by the Staff Development Coordinator for medication administration will be initiated to assure competency and to identify areas of medication administration needing re-education.</p> <p>Monitor for Corrective Action:</p> <p>DNS or designee will monitor results of clinical competencies and the need for additional education related to Medication Administration.</p>		

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DCH/DA/MS/CS

Long

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F 332	<p>Continued From page 46</p> <p>usually in there (the chart). Then the amounts to flush with should be in the MAR" (Medication Administration Record). Review of the resident's chart with Staff D revealed the proper order forms were not where she had stated they were. Additionally, the MAR stated "Flush IV line before and after medication with NS." Staff D acknowledged this was not complete and stated "It should say specifically how much should be given."</p> <p>The failure to ensure proper order forms with specific flushing directions were present resulted in administering an improper amount of NS. This put the resident at risk of her PICC line not functioning properly.</p> <p>RESIDENT #1 During medication administration on 04/02/13 at 7:28 a.m., Staff F was observed to administer Omeprazole (a medication to treat stomach acid) via the resident's gastric tube (g-tube, a specialized tube inserted directly into the stomach for the purpose of administering medications and nutrition). Staff F had turned off the resident's tube feeding approximately 40 minutes prior to the medication administration. After Staff F administered the [REDACTED] she immediately started the tube feeding again.</p> <p>Review of the physician order's stated to "give half hour before meals." Review of Lippincott's 2013 Drug Handbook located at the East Nurse's Station stated, "Give drug at least one hour before meals."</p> <p>Staff F on 04/02/2013 at 7:45 a.m. was asked about the physician's orders to wait half an hour</p>	F 332	<p style="text-align: right;">RECEIVED APR 25 2013 DORLAND SERVICES</p>	

Jerry

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F 332	Continued From page 47 after administration before a meal and Staff F stated "Oh no. That is fine" indicating starting the tube feeding right after administration was "Okay." In an interview 04/02/13 at 2:30 p.m. Staff B (DNS) was asked if staff should follow the physician's orders. Staff B stated "They have to follow the physician's orders."	F 332			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the	F 431	*F431 Corrective Action/s for residents identified to have been affected: Resident #46 and Resident #19 medications found to be expired were discarded. Identification of residents with the potential to be affected: All other medication were audited for expiration date and were discarded if date was exceeded. Measures to prevent recurrence: Ongoing audits for drug expiration dates will be conducted by Staff Development Coordinator. Monitor for Corrective Action: DNS or designee will monitor results of medication audits related to expiration dates of medication and their appropriate disposal.	5/8/13	

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[Handwritten Signature]

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F 431	<p>Continued From page 48</p> <p>Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure medications were stored and discarded according to facility policy and pharmacy standards on three of four units reviewed. Failure to store and discard medications as indicated placed residents at risk to receive medications which were expired.</p> <p>Findings include:</p> <p>COLLECTABLE COURT MEDICATION CART: During initial rounds 03/27/2013 at 8:40 a.m. Tobramycin for Resident #46 was found with an open date of 02/09/2013. Staff S the Licensed Nurse (LN) stated, "That needs to be discarded." Interview 04/01/2013 at 2:12 p.m. Staff B (DNS) stated "I agree . . . I would throw it out after 28 days."</p> <p>Novolog for Resident #19 was found opened and label stated "pull this med by 3/26/2013." Staff S discarded the insulin. Staff B stated "I would expect that to be pulled."</p> <p>CASABLANCA AVENUE MEDICATION CART On 03/27/2013 at 9:15 a.m., Humulin R for Resident #41 was found with an open date of</p>	F 431	<p>Monthly reports from the consultant pharmacist (that includes a review of medication and their expirations dates) will be reviewed at the monthly Quality Assurance meeting assure our practice of medication administration (replacement of expired drugs) is being followed.</p>		

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LORNA BROWN

Lony

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F 431	<p>Continued From page 49</p> <p>02/27/2013. LN Staff E indicated it should be discarded after 28 days and stated "I'll change that out." Staff B on 04/01/2013 at 2:12 p.m. stated "It should be thrown out."</p> <p>WILD WEST MEDICATION CART On 03/27/2013 at 9:21 a.m., Prednisolone 1% ophthalmic solution for Resident #31 was found with open date of 1/20/13. LN Staff F indicated this medication was not being used anymore. Review of the physician's order for prednisone eye drops stated "2 drops OU BID x 7 days R/T redness and itching." Staff B on 04/01/2013 at 2:14 p.m., was asked if this medication should have been discarded after the seven day treatment was completed in January. She stated "Ideally, in a perfect world, yes they would be thrown out."</p>	F 431			

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Lenny