

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

PRINTED: 05/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

1382

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505475	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/02/2013
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NAME OF PROVIDER OR SUPPLIER  WESLEY HOMES HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1122 SOUTH 216TH STREET DES MOINES, WA 98198
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Wesley Homes Health Center on 04/25, 26, 29, 30/13, 05/01 and 05/02/13. A sample of 34 residents was selected from a census 130, which included the closed records of four discharged residents and five supplemental residents.</p> <p>Survey team members included:                  [REDACTED], RN, MN, Nurse Surveyor                  [REDACTED], RN, MN, Nurse Surveyor                  [REDACTED] MSW, Long Term Care Surveyor                  [REDACTED], RN, MSN, Nurse Surveyor                  [REDACTED], RN, MN, Nurse Surveyor</p> <p>The following complaint was investigated during this survey: #2793610</p> <p>The survey team is from:                  Department of Social and Health Services                  Aging and Long Term-Care Support Administration                  Residential Care Facilities Region 2, Unit F                  20425 72nd Avenue South, Suite 400                  Kent, Washington 98032-2388</p> <p>Telephone: (253) 234-6000                  Fax: (253) 395-5070</p> <p><i>Mike Ambrose</i> 5/13/13                  Residential Care Services Date</p>	F 000	<p>This document is not an admission of guilt or that the documentation is factual in findings. Facility is meeting regulatory requirements of Plan of Correction and reserves the right to refute at a later date.</p>	5/31/13
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>AmcDonagh RW DMS</i>	TITLE 5/24/13	(X6) DATE
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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 250 SS=E	<p><b>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</b></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 promote participation in care planning for three of three sample (Resident #119, 66 &amp; 6) and three additional (#146, 127 and 152) residents reviewed. This failure had the potential to negatively impact resident's feelings of independence and involvement in the services they receive. Additionally, the facility failed to provide medically related social services to assist residents with behavioral and/or emotional adjustments for one of three residents (Resident #119) for which these needs had been identified. Finally, the facility failed to have in place a complete and accurate discharge plan for one of three residents (Resident #62) for whom a potential for discharge to a less restrictive environment had been identified.</p> <p>Findings include:</p> <p><b>PARTICIPATION IN CARE PLANNING</b> In an interview on 05/2/13 at 1:00 p.m. administrative nursing Staff B confirmed the facility holds quarterly care conferences in conjunction with the required MDS assessment. The purpose of these care conferences was to</p>	F 250	<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. This requirement was not met related to CARE PLANNING, ASSISTING RESIDENT with BEHAVIORAL and/or EMOTIONAL ADJUSTMENTS; COMPLETING an ACCURATE DISCHARGE PLAN.</p> <p>CARE PLANNING:</p> <ol style="list-style-type: none"> <li>1. A Care Plan review will be completed for each of the residents noted in the survey citation.</li> <li>2. All other resident charts will be audited to determine if a current Care Plan Review is evident, or if a Care Plan review needs to be completed.</li> <li>3. The Care Plan review process will be reviewed with all disciplines involved in the process: Nursing, Social Services, Activities and others as needed (therapy, restorative staff, and dietician).</li> <li>4. The Care Conference scheduling process will be review with Nursing and Medical Records. (Medical Records sends Care Conference invitation).</li> </ol>	5/31/13

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F 250 Continued From page 2  
involve residents and their family/support persons in the care planning process. Medical Records was responsible to notify the family; Social Services was responsible to invite the resident to the care conferences and document if none occur.

**RESIDENT #119**  
Resident #119 has resided in the facility for two years. The facility most recent comprehensive assessment determined the resident was cognitively intact with moderate [REDACTED]. Her care needs were related to multiple [REDACTED] and extensive assistance with most of her activities of daily living.

In an interview on 04/26/13 at 7:45 a.m. the resident stated she had not attended a care conference, but wished they had care conferences.

Record review on 04/30/13 revealed social services facilitated two care conferences in the past 18 months dated October 2011 and November 2012.

Record review of the Nursing Care Plan revealed the social services participation in care regarding Altered Mood State and behavior problems evidenced by depression, attention seeking and allegations about care was to visit resident PRN (as needed).

In an interview on 04/30/13 at 10:00 a.m. the resident stated the Social Services staff, who the resident knew by name, was difficult to talk to. The resident also stated this staff member never

F 250

5. The Director of Social Services and Resident Care Manger will conduct audits to assure that each resident care Plan is review quarterly, or more often if indicated.

6. The Director of Social Services will assure that each resident, and the appropriate responsible party, are invited to participate in the quarterly review of the Care Plan.

7. The Director of Social Services and the Resident Care Managers will conduct audits to assure that appropriate documentation is completed to confirm each review of the residents Care Plan.

**ASSISTING RESIDENT with BEHAVORIAL and/or EMOTIONAL ADJUSTMENTS:**

This requirement will be met by taking the following steps:  
1. Social Service staff will identify residents with behavioral and/or emotional adjustment needs by interviewing the residents at least quarterly; communicating with staff in daily report meetings and via e-mail; reviewing the history and current documentation in the chart.

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came by to see how the resident was doing and was busy when the resident went to talk with this staff.

In an interview on 05/01/13 at 11:15 a.m., Staff N, the RCM, stated nursing services coordinates with social services through the stand-up meetings and the 24 hour report. When asked how nursing followed up on concerns communicated to social services, Staff N again stated through the stand-up meetings and the 24 hour report.

In an interview on 5/01/13 at 1:15 p.m. Staff L of Social Services stated she met with this resident when there were problems. When asked how social services measured the effectiveness of their services, Staff L responded, "I do not know." Staff L went on to say, "She (Resident #119) has an attention seeking behavior, so the more I meet with her the more she wants to meet." Staff L stated the resident was very demanding and when asked if she had formulated a plan to accommodate the resident's needs, she indicated she had not.

**RESIDENT #66**  
This resident has resided in the facility for over three years with care needs related to [REDACTED] resulting in moderate cognitive impairment and extensive assistance for activities of daily living due to a [REDACTED]

In an interview on 04/25/13 at 10:57 a.m. the resident stated she was not involved in her decisions of daily care. She described her care as, "Whatever gets done, happens."

F 250

2. Residents with a history of behavioral and /or emotional adjustment needs will be informed of resources including staff support and professional mental health services.
3. Should a resident decline professional mental health services, the resource information will be offered again during quarterly review, or more often as needed.
4. Actions will be documented in the resident's medical record.
5. The Director of Social Services will complete periodic chart reviews to assure that these measures are implemented.

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In an interview on 04/29/13 at 1:25 p.m., the resident's son and Directed Power of Attorney (DPOA) stated the resident has not been involved in care conferences recently. He has also not attended recent care conferences because he "Deals with things as they come up."

In an interview on 05/02/13 at 9:15 a.m., Staff N stated this resident's son frequently visits the resident and discussion regarding care was on-going. However, Staff N had no documentation of these conversations.

Record review on 05/02/13 revealed no care conferences associated with the MDS assessments dated 12/05/12 and 03/06/13. Additionally, there was no documentation as to the cancellation of the care conferences. The most recent Social Services documentation dated 11/29/12 noted psychosocial well being and mood were to be addressed in the care plan and social services visits were provided as needed (PRN). The care plan reflected no changes for these issues since 04/10/10.

**RESIDENT #6**  
This resident was last admitted to the facility on [REDACTED] 12 with care needs related to [REDACTED]  
[REDACTED]  
[REDACTED], [REDACTED], [REDACTED] and extensive assistance for most activities of daily living.

Record review on 05/2/13 at 9:00 a.m. with administrative nursing Staff B revealed MDS assessments dated 12/21/12 and 02/13/13 did not have any documentation by Social Services involving residents in the care planning process

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F 250	<p>Continued From page 5 or care conference.</p> <p>Staff B confirmed the appropriate procedure for care planning conferences did not occur for resident #119, #66, and #6.</p> <p>Further record review revealed Resident #127 was admitted to the facility April 2011 followed by the only documented care conference on May of 2011. The last two MDS assessments were dated 10/14/12 and 4/11/13 had no corresponding indication the resident or family were offered the opportunity to be involved in the care planning process or care conferences.</p> <p>Record review of Resident #146 revealed an admission date of [REDACTED]/11. The last documented MDS assessments were dated 12/13/12 and 03/12/13 with no evidence of corresponding care conferences. Additionally, there was no indication the resident or family were offered the opportunity to be involved in the care planning process or care conferences.</p> <p>Record review of Resident #152 revealed an admission date of [REDACTED]/11 with a documented care conference on 10/06/11. The next care conference documented was 07/26/12. The last three MDS assessments were dated 09/26/12, 12/26/12 and 03/25/13 with no evidence of a corresponding care conference or the resident and/or family were offered the opportunity to be involved in the care planning process.</p> <p>MEDICALLY RELATED SOCIAL SERVICES RESIDENT #119</p>	F 250	<p>RECEIVED MAY 28 2013 DSHS/ADSA/RCS</p>	

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F 250	<p>Continued From page 6</p> <p>In an interview on 04/26/13 at 7:45 a.m., the resident stated she had not been given notice regarding roommate change. She went on to say her last two roommates had both passed away. On 04/30/13 at 9:30 a.m. the resident elaborated on her experience with a change in roommates. "They don't give me any notice. They just say 'Here's your roommate.' They just brought her in here and put her on the bed." This most recent roommate was transferred to the hospital in March 2013 where she passed away. This experience reminded the resident of family she had lost and stated, "I don't want to go through that again." The resident indicated she had tried to express these concerns to social services.</p> <p>On 04/30/13 at 1:46 p.m., Staff L stated, "I would go and check on her. We talked but I did not document anything." Staff L was not able to provide evidence from the record that bereavement counseling was offered to the resident.</p> <p>Resident #119 had been seen by the same mental health counselor 2-3 times a month until February of 2013. On 04/30/13 at 2:30 p.m., Staff N (Resident Care Manager) and Staff O (Social Worker) reported that Resident #119 declined to continue having counseling because the person who was counseling her for "years" moved on to a different job. Staff stated the resident indicated she would let them know when she wanted counseling again.</p> <p>In an interview 04/30/13 at 4:00 p.m., Resident #119 was asked about her counseling which had stopped and she stated "I asked Staff L, 'When are you going to get that counselor for me?' I</p>	F 250	<p style="text-align: center;"><b>RECEIVED</b> <b>MAY 28 2013</b> <b>DSHS/ADSA/RCS</b></p>	

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never heard anything, so I let it go." When asked if she would like to receive counseling now she stated "Yes." She also stated she did not receive nor was she offered bereavement counseling at the time of her roommate's death.

Review of the Resident Council Meeting Minutes for 09/21/12, 10/19/12 and 11/23/12 revealed Resident #119 attended all three meetings. During the 09/21/12 meeting, under Social Services, it documented "(Resident #119) states that her social worker says she is too busy and has not time to talk to her." During the 10/19/12 meeting, under Social Worker, it's documented "(Resident #119) says that the social worker needs to take time to visit and update on all changes." Finally, during the 11/23/12 meeting also under Social Worker, it's documented "(Resident #119) complains that she her (sic) social worker doesn't come and check up on her regularly." There is no documentation in the Resident Council Minutes how Resident #119's issues concerning receipt of social work support issues had been addressed or if they had been resolved.

For Resident #119, the facility failed to assist her with services which could have maintained or improved her ability to manage her everyday mental and psychosocial needs especially in relationship to the impact her roommate's death in March 2013 had on her.

**DISCHARGE PLANNING  
RESIDENT #62**  
Resident #62 was admitted to the facility on [REDACTED]/13 from an assisted living community setting with multiple medical diagnoses including

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F 250 Continued From page 8  
 [REDACTED], [REDACTED] and [REDACTED] with [REDACTED]

Review of Resident #62's medical record revealed a document titled "Discharge Potential and Planning" with an area marked "Discharge planning is not appropriate at this time" then listing the reasons discharge planning was not appropriate including short term memory loss and inability to monitor or administer medications. The date on the document was 02/19/13.

An interview was conducted with social services Staff O on 04/30/13 at 10:00 a.m. concerning the likelihood the resident could be discharged. Staff O stated discharge discussions were still underway with the issue being the DPOA would like to see Resident #62 discharge back to her previous living conditions but the resident has indicated she "Likes it in the facility" and is amenable to staying long term care.

Staff O stated a trial stay in assisted living was being worked on where Resident #62 could move back into her apartment for one week with medical assistance being provided by the Licensed Nurse (LN) in the assisted living. The only impediment at the time was the DPOA needed to get the resident's belongings out of storage and moved back to her apartment. When asked for a time frame, Staff O stated the hope was to do the trial "Early in May." Staff O stated Staff L would be able to provide additional information since Staff L was the designated social worker for the resident.

An interview was held with social services Staff L on 05/01/13 at approximately 2:15 p.m. When

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informed of the information gathered from Staff O, her supervisor, Staff L indicated discharge planning was not being considered at the time. She stated though the DPOA was interested in discharging Resident #62 back to assisted living, Staff L felt the discharge would not be successful. When asked to review the documentation of the discharge discussions, Staff L said there was none. She stated "I have more than 60 residents. I don't have time to document every little thing."  
  
Failure to establish accurate and documented information concerning potential discharge planning for Resident #62 could result in failure to resolve the differences between Resident #62's desires and those of her DPOA.

F 253 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  
SS=D

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 maintenance services necessary to maintain a homelike and comfortable interior. Failure to repair holes in resident room walls, paint walls, repair damaged flooring and ensure wheelchairs were usable had the potential to diminish the resident's quality of life.

Findings include, but are not limited to:  
  
500 UNIT

F 250 This requirement will be met by taking the following steps:  
1. 500 Unit:  
a. Wall gouges in the following rooms will be repaired and painted. 509, 512, 513, 514, 517, 518, and 519. This operation is ongoing and will be complete by June 7, 2013.  
b. Areas of missing paint in the following rooms will be repainted. 509, 512, 513, 514, 517, 518, and 519. This operation is ongoing and will be complete by June 7, 2013.  
c. Linoleum flooring in all units will be repaired. This work is ongoing and will be complete by June 7, 2013.  
2. 200 Unit:  
a. Areas of missing paint in the following rooms will be repainted. 209, 213, and 215. This operation is ongoing and will be complete by June 7, 2013.  
b. Drawers around the sink in Room 205 will be repaired or otherwise be aesthetically improved. This work will be complete by June 7, 2013.  
c. Linoleum flooring in all units will be repaired. This work is ongoing and will be complete by June 7, 2013.  
3. 100 & 300 Units:  
a. Rooms will be examined for areas of missing paint and damaged furnishings. Issues discovered during this examination will be addressed within 30 days of their discovery.  
b. Linoleum flooring in all units will be repaired. This work is ongoing and will be complete by June 7, 2013.

F 253

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F 253	<p>Continued From page 10</p> <p>Observation on 04/25/13 at 3:36 p.m. revealed in Room 509 the wall behind the bed was heavily gouged, missing both paint and drywall. Room 519 on 04/26/13 at 11:25 a.m. was noted to have gouges in the wall behind the bed, and the wall along the entry into the room above the coving was gouged and missing paint.</p> <p>Room 518 observation on 04/25/13 at 11:40 a.m. revealed the bathroom wall had a one and 1/2 inch by two foot scrape on the wall. Damaged areas in the entryway had been repaired and painted white over visible pink paint. The back wall behind the bed was spattered white and paint had been scraped off. There was a three inch by four inch missing area of linoleum from the front of the bathroom counter. Similar findings were identified in Room 511.</p> <p>Room 513 on 04/25/13 at 11:18 a.m. revealed the wall on the right side of entryway was moderately gouged missing both paint and drywall. A two inch section of the drywall was noted to be caved in. On 04/26/13 at 11:13 a.m. the wall behind the bed in Room 517 was noted to have two vertical gouges six inches long and 1/4 inch wide into the drywall with paint missing.</p> <p>On 04/26/13 at 8:48 a.m. Room 514 was noted to have a wall across from bed one with a gouge revealing wallpaper beneath. The gouge was approximately 18 inches long and four inches wide at one end, tapering down to 1/2 inch. Multiple other scraped areas noted on the wall. The bathroom revealed missing paint and drywall approximately 1/4 inch wide, up to 24 inches long. The heater near bed two was heavily scraped with up to 16 inches by 1/4 inch and 1 inch by</p>	F 253	<p>4. Hand Rails:</p> <p>a. Replacement of handrails with a material that allows ease of cleaning has already been completed for the 500 Unit. All other handrails will be assessed and repairs done as needed by June 7, 2013.</p> <p>5. Wheelchairs:</p> <p>a. The wheelchair used by Resident #196 will be replaced. This will be done immediately.</p> <p>6. Process revisions to ensure adequate future maintenance:</p> <p>a. Maintenance staff will conduct Quality Assurance inspections of each resident room on a rotating basis that covers one Wing (Unit) every month. This will provide at least two inspections per year.</p> <p>b. All staff will be instructed to report areas of major damage (gouged or missing drywall, major floor damage, damaged furnishings) as discovered in the course of their daily duties. Maintenance will complete repairs within 7 working days of reported damage.</p> <p>7. Responsible parties:</p> <p>a. The Environmental Services Director and Maintenance Supervisor will be responsible to ensure Quality Assurance Inspections are conducted, documented, and issues are resolved.</p>	

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F 253	<p>Continued From page 11</p> <p>five-six inch and assorted smaller scraped areas. The wall across from bed two was deeply gouged.</p> <p>Room 520 on 04/25/13 at 11:31 a.m. was noted to have scraped paint and exposed drywall on the wall in the entry. Small divots were observed in the linoleum also in the entryway. The bathroom revealed a scraped area on the lower part of the wall and a small gap in the linoleum.</p> <p>Room 512 on 04/26/13 at 7:59 a.m. revealed the wall behind resident's bed had powdered drywall on the ground. A wooden frame was observed on the floor behind the wheels of the bed. Across from bed one gouged drywall noted with missing patches of up to two by three inches. Multiple divots in flooring measuring one and 1/2 inch by two inches. Missing paint along doorjamb noted. The bathroom had a hole in the wall to the right of the toilet measuring approximately four by two inches.</p> <p>200 UNIT: Observation during initial rounds on 04/25/13 at 8:24 a.m. revealed Room 215 had chipped paint along the doorjamb and a scraped wall in bathroom. Room 209 and 213 had chipped paint on the doorjambs to the bathroom. Additionally, drawers around the sink in Room 205 were scraped and gouged. Similar findings of chipped paint and gouged furnishings in resident rooms were noted on the 100 and 300 units.</p> <p>Hand rails on three out of five units were noted to be worn. Some areas did not have a cleanable surface.</p>	F 253	<p style="text-align: center;"><b>RECEIVED</b> <b>MAY 28 2013</b> <b>DSHS/ADSA/RCS</b></p>	

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F 253	<p>Continued From page 12</p> <p>In an interview 05/01/13 at 2:30 p.m. Staff H (environmental services) indicated they were aware of some maintenance issues. When asked about the hand rails he stated they were going to be replacing the hand rails on every unit eventually. The 500 unit already had new hand rails. Staff H stated they would be replacing the other hand rails as soon as possible. Staff H indicated they are getting new surfaces in resident sink areas with rounded rubber corners along with new drawers. Staff H stated "but we are just getting started."</p> <p>On 05/02/13 at 8:23 a.m. Staff H was shown some of the maintenance issues noted on the 500 unit in rooms 512, 513 and 514. He reported he was not aware of these issues. Staff H was asked what their process was to alert him of maintenance needs or issues. Staff H stated "When the QA meets they focus on one unit at a time. They tell me and I get on it right away."</p> <p><b>WHEELCHAIRS</b> Between 04/29/13 and 05/02/13 daily observations of the wheelchair used by Resident #196 revealed yellow utility tape covered the brake handles. The resident stated until the facility put tape over the brake handles it hurt her hands to use the handles. The resident explained this tape was the facility response to her complaint. Between 04/29/13 and 05/02/13 the tape on the handles became increasingly scraped and frayed.</p>	F 253		
F 272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically</p>	F 272		

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F 272	<p>Continued From page 13</p> <p>a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>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;                      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</p>	F 272	<p>When a resident is known to be usually understood and able to participate in an MDS Interview, sufficient effort will be made to complete an in-person interview with the resident. This requirement will be met by taking the following steps.</p> <ol style="list-style-type: none"> <li>1. Should a resident who is usually understood, appear unable or unwilling to complete an MDS interview, multiple attempts will be made over several days, before proceeding to a staff interview in lieu of an in-person interview.</li> <li>2. Efforts to complete the in-person interview will be documented in the resident's medical record.</li> <li>3. The Director of Social services will complete periodic chart audits to assure this process is being followed.</li> </ol>	5/31/13

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F 272	<p>Continued From page 14</p> <p>by: Based on observation, interview and record review the facility failed to accurately assess two (Residents #187 and 110) of three sample residents reviewed for oral/dental status. This failure created the potential for residents to not receive necessary care and services. Additionally, the facility failed to ensure accurate assessments for Resident #53 (cognitive patterns and mood). Failure to ensure accurate assessments detracted from staffs ability to provide care which residents required.</p> <p>Findings include:</p> <p><b>RESIDENT #187</b> According to the 01/27/13 Admission Minimum Data Set (MDS), Resident #187 was admitted to the facility with care needs related to [REDACTED] and [REDACTED]. According to this MDS, the resident was determined to be edentulous (no natural teeth or teeth fragments).</p> <p>According to dentistry notes dated 02/21/13 the resident was found to have, "edentulous upper arch and lower natural teeth" and assessed as having, "... caries (tooth decay), one fractured tooth (#29) with tissue swelling." A dental hygienist report dated 04/01/13 reflected the resident had, "... fractured teeth ... and suspect decay in (three teeth)."</p> <p>In an interview on 04/26/13 at 10:02 a.m. the resident indicated she had chewing or eating problems which could be due to issues with broken or missing teeth. The resident elaborated, "I have no (upper) teeth up there and I have 8 or 10 teeth down here (bottom arch). The resident</p>	F 272	<p>The facility will accurately assess residents for their oral/dental status. Residents #187 and #110 were assessed for accurate oral status and then their Care Plan and MDS were updated. All residents will be assessed as the MDS comes due by the MDS Coordinator to include a thorough oral exam as recommended by the CMS training video on Oral Health Assessments developed by Dr. Paul Glassman to ensure accurate assessment of their oral/dental status now and ongoing. The MDS Coordinators will assume overall responsibility.</p>	5/31/13

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F 272 Continued From page 15  
stated, "I think my upper plate is at the condo." Observation at this time revealed the resident had no upper teeth and some broken, carious teeth and some missing bottom teeth.

In an interview on 04/30/13 at 2:48 p.m. Staff E (MDS coordinator) stated, "Normally the nurses will write on the initial skin assessment if there is no teeth or teeth (which are broken or carious) . . . then usually on my assessment I will go and check to see if they have new problems." When asked why she coded the residents as having no teeth and did not assess the resident with broken carious teeth Staff E replied, "I don't remember seeing it (broken carious teeth) or I would have coded it."

According to the 02/28/13 CAA (Care Area Assessment) for dental care, "(Resident) has own natural teeth in the lower gum (in the front), with missing teeth on the lower sides, she has no upper teeth /dentures. For now she is tolerating current diet texture w/o (without) problems reported or noted. No bleeding gums, no sores or ulcers noted or reported . . . staff will continue to monitor and will proceed to cp (care plan)." Additionally, there was no evidence staff attempted to locate or contacted family regarding the identified lack of upper dentures.

**RESIDENT #110**  
Record review revealed Resident #110 required treatment for multiple complex medical diagnoses including progressive [REDACTED]. According to the 03/03/13 MDS the resident was completely dependent on staff for all activities of daily living. The resident was unable to participate in an interview.

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F 272	<p>Continued From page 16</p> <p>Observation on 04/26/13 at 10:25 a.m. revealed what appeared to be at least one tooth stump on the lower left mid back and gums which appeared inflamed. Observation of the lunch meal on 04/30/13 and 05/01/13 revealed the resident being fed by staff. Staff were noted to re-spoon food into the residents mouth which had come out of the residents mouth during eating.</p> <p>According to the 10/30/12 and 12/04/12 MDS's, the resident was assessed with no signs or symptoms of a swallowing disorder (no loss of liquids/solids from mouth when eating or drinking), a mechanically altered diet, and "none of the above were present" meaning no edentulous status or broken carious teeth. However, the 12/12 nutrition CAA indicated, "(Resident) continues to receive General fortified liquid diet with HTL (Honey thick liquid) (related to) dysphagia (difficulty swallowing). She is total assist by staff for eating and drinking . . ."</p> <p>According to the alteration in nutrition Care Plan (CP) the resident was at risk for weight loss related to, "therapeutic diet, altered textures, . . . problems swallowing, dysphagia, dementia, (stroke) . . ."</p> <p>The 03/03/13 MDS reflected the resident was now edentulous, but here was no indication in the record of any teeth being extracted. This MDS also indicated the resident had no signs or symptoms of a possible swallowing disorder.</p> <p>In an interview on 04/30/13 at 3:37 p.m. Staff E said, "I don't remember broken teeth, I know she had some teeth on the lower . . ."</p>	F 272		

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F 272	<p>Continued From page 17</p> <p>Observation on 04/30/13 at 4:25 p.m. with Staff E confirmed the resident had broken, carious teeth and tooth fragments. Staff E confirmed at this time, the MDS did not accurately reflect the resident's dental status. Staff failure to thoroughly examine the residents oral status and observe the resident while eating prevented staff from completing an accurate MDS assessment</p> <p><b>RESIDENT #53</b> According to the 11/19/12 MDS Resident #53 was usually understood and usually able to understand conversation and was able to participate in the mental status interview which indicated she was cognitively intact. The 02/18/13 MDS indicated the resident was usually understood and usually able to understand conversation but staff did not interview the resident regarding cognitive patterns or mood, documenting the resident was, "rarely/never understood."</p> <p>In an interview on the morning of 04/30/13, when asked why the resident was assessed as rarely understood, Staff G (Social Worker) stated "the resident wasn't available, or maybe there was something going on with the resident at that time." Staff G stated she waits until the due date to do the assessment and if she is unable to interview the resident on that day, she codes the resident as "rarely/never understood."</p> <p>In an interview on 05/02/13 at 9:40 a.m., Staff B confirmed the entire assessment period should be utilized to complete the MDS and the "rarely/never understood" category, according to the Resident Assessment Instrument instructions, is to be utilized for those residents who are</p>	F 272	<p style="text-align: center;"><b>RECEIVED</b></p> <p style="text-align: center;"><b>MAY 28 2013</b></p> <p style="text-align: center;"><b>DSHS/ADSA/RCS</b></p>	

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F 272	Continued From page 18 incapable of participating in the interview process and whose family/representative is unavailable. Failure to conduct interviews with the resident, prevented the resident from being able to provide insight into her current condition which would enhance good care.	F 272		
F 309 SS=G	<p><b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b></p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide services to maintain the highest practicable physical well being for three of six residents reviewed.</p> <p>Failure of nursing to coordinate services with therapy and assess the possible role pain had in her therapy regimen caused Resident #187 (one of three residents reviewed for pain) to experience pain inducing therapy without benefit of as needed pain medication. This resulted in actual harm to Resident #187 related to the role pain caused in her declination of therapy services. Additionally, failure to ensure staff assessed and reported non pressure related skin issues for two of three residents (#s 53 and 110) placed them at risk for delayed treatment.</p>	F 309	<p>The facility will provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and Plan of Care. Resident #187 was assessed for pain – had a Cortisone shot and again was referred to therapy to reassess for ambulation.</p> <p>The Therapy team met with DNS to review the expectations that they are to go to the residents nurse if the resident that they are treating is having any pain issue. This is done to ensure needed pain medication is provided and to further ensure coordination of care between nursing and therapy. In addition, a communication book has been established for the therapists to write in daily on any resident that they are treating that is having pain issues to ensure follow-up.</p>	5/31/13

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F 309	<p>Continued From page 19</p> <p>Findings include:</p> <p><b>PAIN</b> <b>RESIDENT #187</b> Resident #187 was admitted to the facility on [REDACTED]/13 with care needs related to [REDACTED] and [REDACTED] to [REDACTED]. According to her 01/27/13 Minimum Data Set (MDS) assessment, Resident #187 was assessed to require a scheduled pain medication regimen and had received as needed (PRN) pain medication and non-medication interventions for pain. The resident reported frequent moderate pain which made it hard to sleep at night and limited day to day activities.</p> <p>Observations on 04/26/13 at 9:45 a.m. revealed a well groomed elderly woman sitting in a wheelchair at her bedside. The resident was observed on 04/29/13 to require extensive two person assistance utilizing a mechanical lift, for transferring her from or to her wheelchair.</p> <p>Record review revealed an undated Care Plan (CP) which indicated the resident had "Mobility impairment r/t (related to) bilateral knee pain left greater than right." The goals related to this problem addressed maintaining mobility only, and did not address goals related to pain or how the resident experienced pain with walking. An alteration in comfort CP indicated the resident had bilateral knee pain with interventions that included, "monitor and record any complaints of pain: location, duration, quality and quantity, alleviating factors, aggravating factors; administer medications ([REDACTED] 650 mgs as needed for pain) . . . return to assess effectiveness."</p>	F 309	<p>This book will be checked daily by the therapy supervisor and the RCM for follow-up. RCM has overall responsibility to ensure compliance. Also quarterly in-service will be done by SDC with therapists and nurses regarding Coordination of care between nursing and therapy to ensure appropriate pain medication is provided. Overall responsibility for in-servicing is designated to the SDC. Restorative staff has also been in-serviced to go to the Restorative Coordinator on refusals to ensure an accurate assessment is done based on the refusal to include any possible pain issues. The Restorative Coordinator will in-service yearly and will be responsible for overall compliance.</p>	5/31/13

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Record review revealed the resident had a regularly scheduled order for the [REDACTED] medication [REDACTED] two times a day for 30 milligrams (mgs) each time. Additionally, the resident had a PRN order for [REDACTED] 650 mgs for pain. There were no indications of how frequently nursing staff could administer the [REDACTED] only that it not exceed 3 grams in 24 hours. There was no PRN [REDACTED] medication ordered.

According to an initial Occupational Therapy assessment dated 01/21/13, Resident #187 experienced "Pain at rest = 0/10; pain with movement = 2/10 (Pt stated currently pain at max is a 2/10 sometimes its up to a 14/10 (staff documented 14/10). Pain mainly in L(ef)t knee." (A zero to ten pain scale was utilized by the facility to assess resident's pain. A pain level of zero is no pain, a pain level of five is moderate and a pain level of ten is considered "Worst Possible Pain.")

On 01/22/13, Physical Therapy (PT) staff documented, "(Patient) fearful with complaint of (c/o) left knee pain with onset of treatment . . .". On 01/26/13, PT documented "Continued to complain of right knee buckling and pain in left knee of 8/10." The resident received no PRN pain medication on either of these days even though PT staff documented Resident #187's pain was significant.

PT notes dated 01/29/13 documented "pt (patient) c/o pain with [REDACTED] and standing 9/10 'sharp pain'. Nursing states that pt receives codeine at 9:00 a.m. and 5 p.m. can have add(itional) [REDACTED] PRN. [REDACTED] training after lunch

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pt c/o shaking painful knees." According to the January 2013 Medication Administration Records (MARs), the resident received no PRN pain medication on 01/29/13 even though Resident #187 experienced significant pain.

On 01/31/13, PT staff documented, "Fewer c/o pain with standing today." On 02/01/13, "pt unable to scale pain . . . pt asked about cortisone shot, referred question to nursing. very limited by pain." Staff documented the administration of PRN [REDACTED] at 4:06 p.m., but there was no indication this was administered prior to, or in response, to pain surrounding therapy.

On 02/04/13, PT staff documented Resident #187 was "Unable to scale pain but able to bear minimal weight . . . Pt limited by pain in left knee." According to the February 2013 MARs, the resident received no PRN pain medication prior to or in response to pain experienced related to therapy on this day.

Review of the facility's Care Plan review notes, dated 02/05/13, revealed "Physical Therapy- knee pain . . . (Resident) doesn't want to put weight on it because of pain . . .". This document also stated, "knee is barrier . . . Trouble on and off shower bench - once knee pain is addressed, should do well." A pain assessment developed the same date as the CP indicated, "(R)esident is current working with PT, report to staff that resident c/o L knee pain when ambulating with them."

Record review revealed there was no indication facility staff acted on the knowledge the resident consistently experienced pain with therapy or that

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F 309	<p>Continued From page 22</p> <p>they considered the potential benefit pre-medicating Resident #187 with PRN [REDACTED] prior to therapy might elicit for the resident. Nor did the facility consider rearranging therapy to times when Resident #187's regularly scheduled narcotic pain medication was received in order to maximize the potential relief the reduced pain level might have on the therapy experience for Resident #187.</p> <p>PT staff documented the following: On 02/08/13, "Pt refused to bear wt on left lower extremity stating it felt like it would buckle and too painful." On 02/09/13, "still not bearing weight on LLE (Left Lower Extremity) . . . premedicate secondary to left knee pain? pt c/o left knee pain . . . 4-(to) 8/10." On 02/12/13, a note indicated, "pain decreased from 8/10 to 4/10." During each of the above days, there was no indication Resident #187 received any PRN pain medications.</p> <p>On 02/13/13 PT staff documented, "declined gait today secondary to left knee pain . . . due to increased confusion today (patient) not able to scale pain." On 02/14/13: "Due to pt's pain with mobility she will benefit from wheelchair mobility training." On 02/15/13: "Pt declining to attempt any activity that involves using her legs secondary to left knee pain." On 02/16/13, "assist with lower extremity secondary to knee pain . . . decrease weight tolerance secondary to left knee pain." On 02/17/13: "Pt was very hesitant to start (treatment) and (complained of) pain in left lower extremity . . . standing at rail still caused pain 8/10, pt was unable to extend knee." Review of the 02/13 MARs revealed the resident received no PRN pain medication on any of these days.</p>	F 309		

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Facility staff failed to identify the resident might have benefited from medication related to the pain which was clearly and consistently induced by therapy.

Physical therapy notes dated 02/25/13 indicated the resident had, "refusal to bear weight on the left lower extremity due to fear of buckling and pain . . ." and "due to patient's refusal to bear weight on left leg for gait she was unable to progress with transfers and gait." The resident was subsequently discontinued from therapy services and referred to Restorative therapy.

In an interview at 2:25 p.m. on 05/01/13 Staff I (Physical Therapy Assistant-PTA) indicated she had worked with the resident when she received Physical Therapy and "her pain rating was very high."

In an interview on 05/01/13 at 2:35 p.m., Staff J (Physical Therapist) indicated the resident was evaluated for therapy on 01/21/13 and therapy was discontinued on 02/25/13. Staff J stated that on some days the resident, "wouldn't want to walk (related to) the knee pain." In an interview on 05/07/13 at 4:05 p.m. Staff J indicated she provided therapy in the morning after the resident received her regularly scheduled codeine, but there was no mechanism in place to verify the times other staff members provided therapy. Staff established and documented the resident experienced pain, recognized the resident's refusals were related to pain, but failed to identify and act on the resident's pain needs not being met.

In an interview on 05/02/13 at 8:40 a.m., Staff C

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(Resident Care Coordinator) stated for a resident for whom pain could be anticipated during therapy, "we would give the medication a half hour to 45 minutes before the therapy." While quarterly pain assessments were completed, they did not identify the resident experienced pain with mobility/ambulation. Staff C was unable to explain why Resident #187, who staff documented experienced predictable pain, did not receive PRN pain medication. Staff B, in an interview on 05/02/13, confirmed there was a lack of coordination between therapy and nursing regarding the resident's pain.

Record review revealed the resident received a Restorative program which included range of motion and a walking program six days a week. The Walking RA (Restorative Aide) goal was, "to increase strength on bilateral LE and increase mobility endurance."

In an interview on 05/02/13 Staff M, the Restorative Coordinator, stated "therapy never said anything about her refusing because of knee pain, but they did say she needs more encouragement." In an interview on 05/02/13 at 8:11 a.m. Staff P, Restorative Aide, stated the resident, "participates in everything but the walking . . . (she) doesn't want to do the walking, she says she can't and doesn't want to."

In an interview on 5/02/13 at 8:22 a.m., Resident #187 stated she did not do the walking because she had a bad knee. "It hurts" and "It gives out."

Review of Restorative documents revealed the resident participated in the ambulation program on six of 28 opportunities in March 2013 and

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refused all ambulation in April 2013. There was no indication staff assessed the reasons behind the refusals or considered offering an as needed pain medication prior to the initiation of the resident's restorative program. There was no indication facility staff recognized the resident's refusals were related to fear of experiencing what had become predictable pain or reevaluated what presented as an ineffective pain management program.

**RESIDENT #53**  
Observations on 04/25/13 at 2:07 p.m. revealed Resident #57 sitting on the edge of her bed. The resident was noted to have peeling skin, which appeared red and irritated, at the base of both thumbs. The top layer of skin on the palm of the right hand had separated from the rest of the skin creating the appearance that it could be peeled off in a sheet. Similar observations were noted on 04/26/13 and 04/29/13.

According to the weekly skin assessment sheets dated 04/24/13, the resident had no skin issues. Review of progress notes revealed no documentation to support facility staff were aware of Resident #53's skin issues until a Physician's Assistant (PA) saw the resident on 04/29/13 and documented the resident had, "what appears to be derroofed blister in right palm and at base of left thumb."

According to Telephone orders dated 04/29/13 the PA requested: "Please fit (resident) for fingerless gloves to be used when exercising to protect palms . . . use lotion on palms to promote healing."

F 309

In-servicing has been provided to all NAC's to report any new or noted skin issues to their team leader when observed. Also in-servicing has been provided to all LN's about accurate assessment and documentation of skin issues to include weekly skin assessment charting by the LN. In-servicing will be provided quarterly by the SDC/Skin LN. The RCM will assume overall responsibility and to report any trends to the QA committee for follow-up.

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F 309	<p>Continued From page 26</p> <p><b>RESIDENT #110</b></p> <p>Observation on 04/26/13 at 10:27 a.m. revealed Resident #110 sitting in a Gerichair. What appeared to be an abraded area was noted on the right forehead, red and slightly raised approximately 0.5 cm (centimeters) to 1.0 cm area surrounded by flaky skin. Observation on 04/29/13 at 2:15 p.m. revealed similar findings.</p> <p>Review of weekly skin assessments revealed the resident had no noted skin issues on 04/25/13. Review of progress notes revealed no documentation to support staff were aware of the lesion on the resident's forehead.</p> <p>On 04/30/13 at 2:10 p.m. Staff C was requested to assess the resident' skin and stated, "It looks like a growth, I will have (the physician) look at it."</p> <p>According to a physician's note, dated 04/30/13, "... approximately 1/2 by 1 1/2 cm, elevated slightly erythromatic with some scaling . . . consistent with seborreric keratosis right forehead area."</p> <p>In an interview on 05/02/13 Staff B indicated skin issues could be identified through the weekly skin assessment done by licensed nurses, baths provided weekly by NAs (Nursing Assistants) or when provided care by NAs through the course of the day. Staff B indicated facility staff should have identified and reported these skin issues. She indicated there would be monitoring to determine if the issue became better or worse. Failure to identify and report skin issues placed residents at risk for delayed treatment.</p>	F 309		
F 325	483.25(i) MAINTAIN NUTRITION STATUS	F 325		

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F 325 SS=D	<p>Continued From page 27 UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review one (Resident #197) of three residents reviewed for weight loss did not receive prompt dietary intervention for facility identified weight loss. The resident was not reviewed by the Registered Dietician from 03/04/13 until 03/18/13 while the resident experienced an 8% weight loss (10.5 pounds).</p> <p>Findings include:</p> <p>The facility's undated policy "Components of Nutrition at Risk Program" stated "Monthly audit of all weights back six months with list generated of residents whom require assessment for change of weight. List of change weights includes 5% change, 7.5% change, 10% change or if outside recommendation of RD (Registered Dietitian) recommended parameter." The Nutrition at Risk Committee includes at a minimum RD (as available), RN, DNS. It further</p>	F 325	<p>In order to address citation and to streamline current processes we propose the following Plan of Correction:</p> <ul style="list-style-type: none"> <li>On Tuesday of each week a list of residents to be discussed at the weight meeting requiring RD intervention and consultation is emailed to both the RD's with hard copy delivered to office. Propose doing this by hall (100, 200, 300 etc), This list will not include all residents who are subject to discussion in the weekly weight meeting only to those residents requiring intervention and consultation and are entered into weight books.</li> <li>Weight meeting occurs per current practice</li> </ul>	5/31/13
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F 325	<p>Continued From page 28</p> <p>stated "Good communication between nursing and dietary to ensure recommendations are followed."</p> <p>In an interview on 04/29/13 at 10:30 a.m. when asked how nursing made referrals to the RDs for weight loss, the Registered Dietician, Staff S replied either the staff stops them in the hall, goes through the "Dietician Referral Log" or sends the RDs an e-mail.</p> <p>Resident #197 was admitted to the facility on [REDACTED]/13 and was discharged [REDACTED]/13 to her home making the resident unavailable for interview or observation. Admission diagnoses included multiple medical problems including [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. During her nursing home admission, Resident #197 was not on a physician prescribed weight loss program. Review of the resident's record revealed a [REDACTED]/13 admission weight of 148.2 pounds (lbs).</p> <p>The Nutritional Risk Review dated 02/20/13 identified the residents intake was 49%. The 02/20/13 Nutritional Risk Assessment completed by the RD indicated the resident's intake was fair, but wasn't meeting caloric/protein needs and identified the resident was at risk for unintended weight loss related to [REDACTED], a history of weight loss and a poor appetite. The nutritional goals included a weight of 144 to 153 lbs.</p> <p>According to the weight record on 02/22/13, the resident's weight had decreased to 144.1 lbs. On 02/26/13 nursing documented a referral to the Dietician for Weight Gain. According to the 03/01/13 Minimum Data Set (MDS) the resident</p>	F 325	<ul style="list-style-type: none"> <li>• Consultation by RD completed within 7 days of referral and noted appropriately as per current practice.</li> <li>• The dietitians will continue to independently follow a referred resident with significant weight loss until it is determined that the resident is nutritionally stable for one month or that maximum dietary interventions have failed and further weight loss is expected and unavoidable.</li> <li>• All other procedures remain the same. This applies to diet order changes, standard requests for RD consultation etc.</li> </ul>	5/31/13

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weighed 135 lbs which was a 13 lb. and 8.8% weight loss since admission.

The dietician did not see the resident until 03/04/13 in response to the referral by nursing. The RD documented assessment included "Res(ident) with significant weight loss in less than two weeks, approximately 10 lbs. Appetite has improved since admit to 66%." The RD added fortified foods to the resident's diet and decreased the goal weight to between 131 and 139 lbs. In an interview on 04/29/13 at 10:30 a.m. Staff S said the RDs do not see residents again for follow up unless nursing makes another referral.

Review of Resident #197's medical record revealed the resident's lowest weight of 123.7 pounds occurred on 03/11/13. There was no documented referral to the RD as indicated by the RD ordered parameters at this time. On 3/12/13 staff recorded Resident #197's weight as still below the parameter at 127.6 lbs. A 03/12/13 Nutritional Risk Review by nursing identified the resident's continued weight loss, noted the resident's appetite was poor, "eats only 39% of all meals." The plan documented was "RD referral made." Review of the Dietician Referral Log revealed the dietician did not assess the resident until 3/18/13.

During the interview with administrative nursing Staff B on interview on 05/02/13 at 8:10 a.m., when asked about the delay of the RD in seeing the resident, Staff B stated "It occurs sometimes and nursing will step in and do a temporary order for supplements, etc., until the resident can be seen by the RD." Staff B went on to state it

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F 325	<p>Continued From page 30</p> <p>"Often feels like an RD intervention quicker would be better."</p> <p>According to the 03/18/13 MDS the resident's weight at 30 days after admission was 124 pounds which was a 24 pound weight loss from admission or a 16.2% loss. The 03/18/13 RD Progress notes identified the resident had significant weight loss of 19% in the last month which the RD attributed to edema and C diff. No further nutritional interventions were implemented and the RD further lowered the goal to maintain the resident's weight between 120-128 lbs.</p> <p>In an interview on 05/02/13 at 8:10 a.m. Staff B indicated the residents who required a referral to the RD were generated from the weekly weight loss or "Nutrition at Risk" meetings held between Staff B and the Resident Care Managers (RCMs). Staff B indicated the RD did not attend the weekly nutrition meetings and added stated "It's always been that way. They are just too busy to attend."</p> <p>Failure of the facility and the consulting dietician staff to establish effective communication channels concerning resident weight loss and the consultant dietician failure to establish a methodology to continue to track residents with dietary issues resulted in Resident #197 sustaining substantial weight loss prior to sufficient interventions being implemented.</p>	F 325		
F 328 SS=E	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services:</p>	F 328		

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F 328	<p>Continued From page 31</p> <p>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 three of three sample (#110, 36, and 6) and two supplemental (#s 21 &amp; 141) residents reviewed received proper treatment and care related to respiratory needs. Failure to ensure a system by which oxygen equipment was properly maintained placed residents at risk for malfunctioning equipment.</p> <p>Findings include:</p> <p>RESIDENT #110 Observation on 04/29/13 at 11:50 a.m. revealed Resident #110 receiving oxygen from a concentrator which had an oxygen filter heavily coated with dust. Similar observations were made on 04/26/13 and 04/29/13.</p> <p>On 04/29/13 at 1:03 p.m., Staff R (Licensed Nurse) was observed to remove the filter on Resident #110's concentrator, revealing one side which was so dusty it appeared whitish/gray, and the inside was black. Staff R confirmed at that time, "yes it's dirty."</p> <p>In an interview on 04/29/13 at 1:15 p.m., Staff C</p>	F 328	<p>The facility will ensure that oxygen equipment is properly maintained. For resident #110 and #21 and resident #6 the oxygen filters were immediately cleaned during survey as were all other oxygen filters house wide. Resident #36 had a new filter provided the same day it was noted missing. Resident #141 was provided with a new oxygen concentrator the same day it was noted to have issues. Noc nurses have been in-serviced to proper cleaning of filters. The NOC LN is to sign off completion of this weekly in the Mini-mar. Sound Oxygen Company checked all oxygen machines to ensure proper functioning during survey and will continue to do so bi-annually. RCM's/DNS will ensure compliance.</p>	5/31/13

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F 328	<p>Continued From page 32</p> <p>(Resident Care Manager) indicated, "The nurses clean the filters . . . we have a schedule . . . every week night shift Tuesday." Observation at that time of the nebulizer at the resident's bedside revealed a tanish residue around the nebulizer filter. Staff C was unable to remove the filter.</p> <p>Staff C elaborated that nursing staff was responsible for cleaning the oxygen machines and nebulizers. Resident #110's concentrator was noted with drips/debris on the face of the machine. Staff C also confirmed at this time the concentrator filter was not clean.</p> <p>Record review revealed directions to staff to change and date nebulizer tubing, but there was no direction to staff to change/date oxygen tubing or clean nebulizers. At 2:15 p.m. on 04/29/13 Staff C reiterated that while there was no written direction, it was the expectation that nightshift staff perform these duties once a week.</p> <p><b>RESIDENT #21</b> Observation on 04/29/13 at 11:54 am, revealed Resident #21 receiving oxygen via nasal cannula, the filter in the back of the machine was noted to be moderately coated with dust. The oxygen concentrator faceplate was missing but noted on a nearby counter.</p> <p><b>RESIDENT #36</b> Observations on 04/29/13 at 12:04 p.m., revealed the resident wearing a nasal cannula. The nares on cannula turned out /down not in residents nose, decreasing the effectiveness of the intended oxygen flow. Observations on 04/26/13 revealed the resident's oxygen concentrator at the bedside had no foam filter. The plastic grid</p>	F 328		

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F 328	<p>Continued From page 33</p> <p>which would hold a filter was moderately coated with dust.</p> <p>Observation of the absent filter was confirmed by Staff R (Licensed Nurse) at 1:08 p.m. who stated, "Oh it needs a filter." At this time two pieces of lint/dusty debris approximately 1 1/2 inches long were extracted from the back of the machine. Staff R stated, "Oh we should tell the company because we don't keep the parts, they would have them . . ." Staff R indicated the contracted oxygen company was responsible for the upkeep of the machines and, "we would tell them it needs repaired or checked."</p> <p>RESIDENT #141 Observation at 12:09 p.m. on 04/29/13 revealed Resident #141's oxygen concentrator was missing the dial which allowed staff to adjust oxygen flow. At 1:20 p.m. on 04/29/13, Staff C confirmed the adjustment dial was missing.</p> <p>RESIDENT # 6 Observations on 04/26/13 and 04/29/13 revealed dust covered filter on the back of the oxygen concentrator and dust and debris was caked to various areas on the front of the machine. On 4/26/13 the medication nurse explained the nursing staff is responsible to change tubing on the oxygen concentrators and maintenance is responsible to keep the machines clean.</p> <p>In an interview on 04/29/13 at 2:55 p.m., Staff Q, Sound Oxygen Services, indicated, "I am checking the machines to make sure they work . . ." He indicated the filters should be kept clean, "they (filters) should be black, if its white, it's probably not clean." Staff Q further indicated that</p>	F 328		

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F 328	Continued From page 34 while the resident can't breath in the dust, the dust can interfere with the motors function, rendering the machine ineffective.  In an interview on 4/30/13 at 2:54 p.m. administrative nursing Staff B stated that oxygen equipment filters should be cleaned once a week by night shift. She concurred based on survey and staff report that this had not been occurring.	F 328		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	The facility will ensure each resident's drug regimen is free from unnecessary drugs. Resident #53 diagnosis of TD was discontinued by the ARNP. All residents will be assessed by Psychotropic Committee to ensure proper diagnosis. Resident #80 and #109 had the Pantoprazole and Prilosec discontinued respectively. All residents on an PPI were assessed by the MD for continued need of medication and medication was dc'd if appropriate. RCM's will monitor to ensure on going compliance along with the Pharmacist. ADNS will assume overall responsibility.	5/31/13

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F 329	<p>Continued From page 35</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to ensure adequate monitoring, continued need of use and/or indications for use for three (#s 80, 109 and 53) of 10 residents reviewed for unnecessary medications. These failures placed residents at risk for adverse side effects and/or to receive unnecessary medications.</p> <p>Findings include:</p> <p><b>RESIDENT #53</b> Record review revealed the resident was admitted to the facility on [REDACTED]/11 and according to the 02/18//13 annual MDS (Minimum Data Set) had care needs related to [REDACTED] and [REDACTED]</p> <p>Review of 04/13 Physician Orders (POs) revealed the resident received the [REDACTED] medication [REDACTED] for "TD ([REDACTED], a [REDACTED] associated with long term use of high doses of [REDACTED]ic medications)" and [REDACTED]. Further record review revealed the resident received [REDACTED] every day since admission for TD and had an [REDACTED] diagnosis added in 10/12.</p> <p>According to the Nursing 2012 Drug Handbook located at the nurses station and used by the nurses as a drug reference book, there was no indication [REDACTED] was indicated to treat TD. Additionally, there was no documentation facility staff ever identified the symptoms [REDACTED] was required to treat for TD.</p>	F 329		

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In an interview on 05/01/13 at 12:11 p.m. the Resident's PAC (Physicians Assistant Certified) stated, "we do monitor for anxiety . . .we should get rid of the TD diagnosis as we are not seeing TD with her." The PAC further indicated [REDACTED] was not used to treat TD.

In an interview on 05/01/13 at 11:50 am, Staff C indicated, "I am sure we are not monitoring for that (TD)." Failure to identify the resident demonstrated symptoms which required the use of [REDACTED] from the time of admission to 10/12 constituted the use of an unnecessary medication. Continued failure, from 10/12 to 05/13, to monitor symptoms associated with TD, detracted from staffs ability to determine continued need for this drug.

RESIDENT #80  
According to the 02/06/13 MDS, Resident #80 was assessed to have diagnoses including [REDACTED] was usually understood and usually able to understand conversation, and had a BIMS (Brief Interview for Mental Status) score of 11, reflective of moderate cognitive impairment.

Record review revealed the resident received the medication [REDACTED] since 05/04/12. According to the Nursing Drug 2012 drug handbook located at the nurses station this medication had indications and dosages as follows: "for [REDACTED] .40 mg PO (orally) once daily for up to 8 weeks. For patients who haven't healed after 8 weeks of treatment, another 8 week course may be considered." Long term use of this medication was indicated for "maintenance of healing erosive esophagitis and reduction in

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relapse rates for daytime and nighttime heartburn symptoms in patients with GERD" however, there was no indication in the record the resident had erosive esophagitis. Additionally, in an interview on 05/01/13 at 11:12 a.m. Staff C stated there was no indication in the record Resident #80 had complained of gastrointestinal (GI) upset and no indication staff had considered if the resident continued to require the use of the medication.

**RESIDENT #109**  
According to the quarterly MDS dated 03/24/13 Resident #109 had multiple diagnoses including [REDACTED]. Record review revealed a Care Plan (CP) which indicated the resident had an, "Alteration in Health maintenance secondary to [REDACTED]. There were no goals related to the [REDACTED] and no intervention regarding [REDACTED] except, "[REDACTED] (over the counter) 20 mg (milligrams) po (orally) qd (each day)."

According to the Nursing 2012 Drug Handbook located at the nurses station and used by the nurses as a drug reference book, "symptomatic gastroesophageal reflux disease ([REDACTED]) without esophageal lesions" is treated with "20 mg po . . . daily for 4 weeks for patients who respond poorly to customary medial treatment, usually including an adequate course of H-2 receptor antagonists." There was no indication in the record the resident had erosive esophagitis or accompanying symptoms caused by [REDACTED] or the medication was used to treat or prevent a drug induced gastritis or esophagitis or a less GI-toxic analgesics.

Review of Physician Orders and Medication Administration Records (MARs) revealed the

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resident had received [REDACTED] since admission in 09/12. The resident was on [REDACTED] for greater than 8 weeks, without evaluation of continued need/effectiveness of medication.

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