



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

PRINTED: 09/05/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505324</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/21/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF PUYALLUP</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>511 10TH AVENUE SOUTHEAST PUYALLUP, WA 98372</b>		
(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 000	Continued From page 1	F 000			
F 156 SS=D	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p>	F 156			

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F 156	<p>Continued From page 2</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use</p>	F 156	<b>IDR AMENDED</b>	

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F 156	<p>Continued From page 3</p> <p>Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and closed record review, it was determined that the facility failed to give advance notice regarding Medicare status to 2 of 3 Sampled Residents(#s 133 &amp; 189)reviewed for liability out of the 47 residents who were included in the Stage 2 review. This failure place both residents at potential risk of not being able to exercise their rights regarding liability and appeal review of Medicare benefits.</p> <p>Findings include:</p> <p><b>RESIDENT #133</b> On 6/14/13 at 1:55 p.m. Staff R reported Resident #133 was admitted to the facility on [REDACTED] 13 and discharged on [REDACTED] 13 with 43 days of Medicare coverage left. Staff R reported the facility did not give the resident notice that he/she had 43 Medicare days of coverage left.</p> <p><b>Resident #189</b> On 6/14/13 at 1:55 p.m. Staff R reported Resident #189 was given a notice services furnished to the resident no longer qualified as covered under Medicare beginning on 1/4/13. Staff R reported the resident had 59 Medicare days remaining.</p> <p>Review of a form titled: "SNF Determination on Continued Stay", a form used by the facility to notify residents of their Medicare status, dated 1/3/13, notified Resident #189 he/she no longer</p>	F 156	<p><b>IDR AMENDED</b></p>	

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F 156	Continued From page 4 qualified for Medicare services effective 1/4/13. Documentation on this letter noted Resident #189 signed receipt of the letter on 1/4/13.  On 6/20/13 at approximately 10:00 a.m. Staff A, Staff B and Staff M were briefed Resident #189 was determined by the facility to no longer qualify for Medicare skilled nursing services on 1/4/13 and was given notice on the same day of the facility's determination (1/4/13) and Resident #133, who was admitted to the facility on [REDACTED] 13 and was discharged from the facility on [REDACTED] 13 and who remained on Medicare during the entire stay, was not given notice of Medicare days remaining before or after the resident was discharged on [REDACTED] 13  On 6/21/13 at approximately 9:40 a.m. Staff A, Staff B and Staff M did not provide further evidence of notification of Medicare status to Residents #133 and #189.	F 156			
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE  A resident has the right to receive notice before the resident's room or roommate in the facility is changed.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to consistently inform each resident in advance prior to a new resident being admitted into the same room for 1 of 3 Sampled Residents (#12) reviewed for change in roommates out of the 47	F 247			

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F 247	<p>Continued From page 5</p> <p>residents who were included in the Stage 2 review. This failure placed Resident #12 at potential risk for emotional distress.</p> <p>Findings include:</p> <p>During an interview on 6/11/13 at 2:17 p.m. Resident #12 reported she had five new roommates since she was admitted on [REDACTED]/13. Resident #12 further reported she had never received notice of a new roommate prior to the new roommate's arrival.</p> <p>During an interview on 6/17/13 at 11:55 a.m. Staff R reviewed the admissions for the named resident's room and confirmed there had been five people admitted into the same room as Resident #12 since 3/1/13.</p> <p>During an interview on 6/17/13 at 10:00 a.m. Staff D reported when a new resident is being admitted to the facility the existing roommate is informed in advance and it is then documented in the social services progress notes.</p> <p>Review of social services progress notes revealed no documentation to evidence Resident #12 had been informed of receiving a new roommate at any time since she was admitted to the facility.</p> <p>During an interview on 6/17/13 at 11:30 a.m. Social Services Staff G reported when informing a resident that he/she will receiving a new roommate it is documented in either the nursing or the social services progress notes. Staff G then reviewed Resident #12's record and was not able to locate any documentation to support the resident had ever been informed of receiving a</p>	F 247	<b>IDR AMENDED</b>		

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F 247	Continued From page 6 new roommate.  Staff G then called the admissions office, who informed her that the notification is not documented as the hospitality aid who does the notification does not have access to the computer.  During an interview on 6/17/13 at 1:30 p.m. Staff K reported the facility has a check off list of things to do when a new resident admits to the facility. After reviewing the list, Staff K confirmed that notifying the existing roommate was not included on the list. Staff K further reported when a new resident admits to the facility staff document in the existing resident's record that he/she had been notified that a new roommate will be arriving. Staff K then confirmed the notification to the existing roommate had not always been documented.  Resident #12 reported the facility had not given her prior notice before each of the five new roommates had arrived in her room. The facility was not able to provide evidence they had given prior notice. Failure to give prior notice placed potential emotional distress.	F 247			
F 253 SS=D	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	F 253	<b>IDR AMENDED</b>		

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F 253	<p>Continued From page 7</p> <p>by:</p> <p>Based on observation and interview it was determined that the facility failed to maintain oxygen concentrators in clean condition on 1 of 4 Halls (400 Hall) for 5 Sampled Residents (#s 88, 93, 95, 158 &amp; 163). The facility also failed to maintain fans in clean condition on 2 of 4 Halls for Sampled Residents (#s 40, 145 &amp; 155) and in the 300 Hall Shower Room and in the Laundry Room. This had the potential to compromise function of oxygen concentrators, the quality of air breathed by residents or for dust to blow onto fresh laundered linens and clothes. In addition, the facility failed to maintain an environment free of odors on 1 of 4 wings (400 Wing) of the facility. This failure placed residents residing on the 400 hall at potential risk for a diminished quality of life.</p> <p>Findings include:</p> <p><b>OXYGEN CONCENTRATORS</b></p> <p>During environmental rounds on 6/19/13 beginning 7:10 a.m. on the 400 Hall, Resident #88, Resident #93, Resident #95, Resident #158 and Resident #163 had oxygen concentrators located by their bedside. The concentrators did not have removable filters to filter dirt out of the ambient air before entering the machine. The empty filter holder contained a thick, visible coating of dust.</p> <p>Resident #93, Resident #95 and Resident #163 all breathed oxygen through a nasal cannula at this time. A nasal cannula consists of a lightweight tube connected to the oxygen concentrator (oxygen supply) that has two short prongs placed in the opening of the nostrils. Residents breathed supplemental oxygen through the tube produced by the concentrator.</p>	F 253		
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F 253	<p>Continued From page 8</p> <p>Resident #93 reported he/she used oxygen "a lot." Resident #95 reported he/she wore oxygen all the time.</p> <p>Resident #163 lay in bed asleep.</p> <p>Resident #88's oxygen concentrator had a black filter in the designated space. The filter appeared white with a visible coating of dust.</p> <p>On 6/19/13 at 8:57 a.m. Staff T looked at Resident #88's filter and observed it contained a coating of dust. Staff T reported Staff S took care of oxygen concentrator machines.</p> <p>On 6/19/13 at 9:25 a.m. Staff S reported oxygen concentrators came from an outside contractor and oxygen filters were on back order for over a month now. Staff S reported the company just received filters and would deliver them today.</p> <p>Staff S explained the cleaning schedule included weekly washing the outside of the concentrator and changing and dating oxygen tubing. When asked how often the filters and holders were cleaned, Staff S reported vacuuming the back under the filter would be added to the cleaning schedule. Staff S reported "I think it would help not to collect dust" and without a filter, dust collected more than normal.</p> <p><b>RESIDENT ROOM FANS</b></p> <p>1. On 6/12/13 at 7:40 a.m. Resident #155 had a dark colored stand up fan in the room. The edges were discolored with gray and coated with dust. The spokes on the outside covering also contained a thin coat of visible dust.</p>	F 253	<b>IDR AMENDED</b>	

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F 253	<p>Continued From page 9</p> <p>The following observations took place during environmental rounds on 6/19/13 between 7:10 a.m. and 11:00 a.m.</p> <p>2. Resident #40 had a large, tall white floor fan approximately four feet tall in the room next to the left side of the bed. The resident reported it was his/her personal fan. The fan cover measured approximately two feet wide. Visible dust coated the edges of the fan blades and edges of the spokes on the fan cover.</p> <p>The resident reported he/she used the fan to get air through the room and during the summer months.</p> <p>3. Resident #145's room contained a large gray fan approximately three and a half feet tall. Visible dust coated the edges of the fan blade inside. The resident lay in bed and appeared to be asleep.</p> <p><b>SHOWER ROOM 300 HALL</b> During environmental rounds on 6/19/13 the wall in the 300 Hall shower room had a fan covered with a fan cover on the back wall. The fan had a visible coating of dust on the blades and on the grid cover.</p> <p><b>LAUNDRY ROOM FAN AND VENT</b> 1. On 6/18/13 at 9:45 a.m. a ceiling vent in laundry room across from the washing machines had multiple visible multiple strings of dust, measuring approximately two to three inches long, hanging from the vent slat covering.</p> <p>On 6/19/13 at 10:22 a.m. the same ceiling vent cover that measured approximately 18 inches square had a visible coating of dust on the vent</p>	F 253	<b>IDR AMENDED</b>	

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F 253	<p>Continued From page 10</p> <p>slat. Staff W reported laundry staff "just sweep it off", every other day. Staff W reported using a broom to sweep it off the dust because of the high reach of the vent or otherwise staff would need a ladder to reach it.</p> <p>2. On 6/19/13 at 10:22 a.m. a large fan secured on the wall at the end of the folding area had visible dust collected near the bottom of the fan on the inside of the fan cover.</p> <p>3. On 6/19/13 at 10:22 a.m. a second fan approximately 18 inches wide placed on top of the washing machine blew toward the folding area. The fan contained visible dust on the outside spokes of silver colored fan and had visible dust coating the blades inside. Staff X reported "I leave it (fan) on when I'm on shift."</p> <p>Staff Y reported housekeeping staff cleaned all the fans including the laundry room and we "keep an eye on them."</p> <p><b>ODORS ON THE 400 WING:</b> On 6/10/13, during initial rounds, at 12:45 p.m., a urine smell was noticeable in the hallway on the 400 wing.</p> <p>On 6/14/13 at 11:40 a.m. and at 1:00 p.m. a offensive stale sour smell was noticeable on the 400 hallway.</p> <p>On 6/18/13 at 9:16 a.m. and at 10:02 a.m. offensive odors were present in the hallway on the 400 wing.</p> <p>On 6/18/13 at 12:03 p.m. and at 2:10 p.m. offensive odors were noticeable in the hallway of</p>	F 253	<p style="text-align: center;"><b>IDR AMENDED</b></p>	
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F 253	Continued From page 11 the 400 wing.  On 6/19/13 at 8:32 a.m. a stale odor was noticeable in the hallway of the 400 wing.  On 6/20/13 at approximately 10:00 a.m. Staff A, Staff B and Staff M were briefed their were odors on the 400 Wing of the facility during multiple days of the survey.  On 6/21/13 at 9:30 a.m. Staff B agreed their were odors on the 400 Wings.  Failure to ensure the 400 wing was free of odors potentially impacted the quality of life of the residents living on the 400 wing.	F 253		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to follow professional standards of practice by failing to: A. Correctly calculate dosages of insulin according to the physician's orders for 4 of 12 Sampled Residents (#s 119, 155, 158 & 263). B. Failed to monitor effects of medications for 3 of 12 Sampled Residents (#s 93, 119 & 295). In addition the facility C. Failed to administer medications as ordered by the physician for 3 of 12 Sampled Residents	F 281		

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F 281	<p>Continued From page 12 (#s 56, 293 &amp; 294).</p> <p>Findings include:</p> <p>WAC 246-840-705 Functions of a registered nurse and licensed practical nurse states, "The registered nurse functions in an interdependent role when executing a medical regimen under the direction of an advanced registered nurse practitioner, licensed physician and/or surgeon, dentist, osteopathic physician assistant. " According to Smith, Duell and Martin, Clinical Nursing Skills, Sixth Edition, pages 518-521, nurses are to administer medications as ordered by the physician. Additionally, nurses are to document the time of administration, route, dosage, and assess and document the resident's response to the medication. Nurses are to review the Medication Administration Records daily to validate all medications are in accordance with the physician's.</p> <p><b>A. FAILURE TO CORRECTLY CALCULATE INSULIN DOSAGES RESULTING IN MEDICATION ERRORS</b> RESIDENT #119 On 6/12/13 at approximately 12:00 noon Resident #119 was using an electric wheel chair to move through the halls of the facility and interacting with staff and other residents.</p> <p>Review of Resident #119's May 2013 and June 2013 noted multiple doses errors in insulin administration.</p> <p>Please refer to F333 Resident #119 for failure medication errors in insulin administration.</p> <p>RESIDENT #155</p>	F 281	<p style="text-align: center;"><b>IDR AMENDED</b></p>	

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F 281	<p>Continued From page 13</p> <p>Refer to F 333 for additional information, interviews and record review related to insulin medication errors for Resident #155.</p> <p>Licensed staff did not follow physician orders and administered the wrong dose of insulin six times to Resident #155 during May 2013 resulting in significant medication errors.</p> <p><b>RESIDENT #158</b> On 6/13/13 at 7:29 a.m, Resident #158 was in the main dining room getting ready for breakfast.</p> <p>Review of Resident #158's June 2013 Medication Administration Record (MAR) and May 2013 MAR noted multiple insulin medication errors.</p> <p>Refer to F333 Resident #158 for failure of licensed nurses to administer insulin as ordered by the physician resulting in multiple insulin medication errors.</p> <p><b>RESIDENT #263</b> Resident #263 admitted to the facility on [REDACTED]/13 with diagnosis to include [REDACTED]</p> <p>Review of Resident #263's May 2013 MAR revealed during the 10 days in May that the resident was at the facility she was given the wrong dose of medication 5 times.</p> <p>Resident #263's June 2013 MAR was reviewed on 6/13/13. Review of the record revealed in the first 12 days of June Resident #263 had been given the wrong dose of insulin nine different times.</p>	F 281	IDR AMENDED	

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F 281	<p>Continued From page 14</p> <p>During an interview on 6/17/13 at 5:24 p.m., Staff B reviewed the May and June 2013 MARs and confirmed the calculation errors which led to the wrong dose of medication being administered.</p> <p>Refer to F333</p> <p><b>B. FAILURE TO MONITOR THE EFFECTIVENESS OF MEDICATIONS</b></p> <p><b>RESIDENT #295</b> Resident #295 was admitted on [REDACTED]/13 for rehabilitation care following a surgical procedure. On [REDACTED]/13 at 11:38 a.m. Resident #295 was ambulating using a walker with physical therapy.</p> <p>Review of the Resident #295's MAR for June 2013 between the dates of 6/8/13 and 6/18/13 noted licensed staff did not consistently monitor a controlled [REDACTED] medication for pain management.</p> <p>Refer to F329 Resident #295 for failure to monitor the effectiveness of a controlled [REDACTED] medication used for pain control.</p> <p><b>RESIDENT #119</b> Review of the Resident #119's May 2013 (MAR) and June 2013 MAR noted inconsistent monitoring of the a controlled [REDACTED] given to the resident for pain management.</p> <p>Refer to F329 Resident #119 for failure to monitor the effectiveness of a controlled [REDACTED] medication used for pain control.</p> <p><b>RESIDENT #93</b> On 6/14/13 at 7:34 a.m. Resident #93 was seated</p>	F 281	<p style="text-align: center;">IDR AMENDED</p>	

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F 281 Continued From page 15 in a wheel chair in her room. The resident was watching television and was very sleepy.

Review of the resident's MAR(s) for May 2013 and June 2013 noted no monitoring of the effectiveness of the resident's prescribed supplement for [REDACTED]

Refer to F329 Resident #93 for failure to monitor a prescribed supplement used for [REDACTED].

**C. FAILURE TO ADMINISTER MEDICATIONS AS ORDERED BY THE PHYSICIAN**

**RESIDENT #56**  
Resident #56 admitted to the facility on [REDACTED]/13 with multiple diagnoses to include [REDACTED].

Review of the record revealed a physician's order dated 5/8/13 for [REDACTED] 800mg by mouth as needed with snacks (medication that reduces blood levels of phosphorus in people with chronic [REDACTED] who are on [REDACTED]).

Review of May 2013 and June 2013 medication administration records (MAR) revealed the order did not get carried over onto either MAR to direct staff to give the medication when needed.

On 6/18/13 at 8:25 a.m., during an interview, Staff AA confirmed the medication did not get carried over onto the May 2013 and June 2013 MAR's.

Failure to carry over physician orders onto the MAR, placed the resident at risk to not receive the medication according to the physician's order.

F 281

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F 281	<p>Continued From page 16 Refer to F333.</p> <p><b>RESIDENT #293</b> Refer to F 333 for additional resident information, observations, interviews and record review related to medication error from [REDACTED] for Resident #293.</p> <p>On 6/9/13 the physician ordered for staff to administer a 25 mcg/hour (h) patch to Resident #293 for treatment of chronic pain. On 6/12/13 the physician increased the dose of the patch to 50 mcg/h.</p> <p>When staff applied the 50 mcg/h patch they did report to administration they could not locate the 25 mcg/h patch applied three days earlier on 6/9/13.</p> <p>On 6/12/13 at 7:23 a.m. the resident had two 25 mcg/h patches (total of 50 mcg/h) on the left chest and also a 25 mcg/h patch on the upper back dated applied earlier on 6/9/13 for a total of 75 mcg/h. Resident #293 had additional medication available to absorb from the [REDACTED] [REDACTED] previously applied on 6/9/13 in addition to the 50 mcg/h the physician currently ordered and applied.</p> <p><b>RESIDENT # 294</b> Resident #294 was admitted to the facility on [REDACTED] 2013 with multiple diagnoses to include end [REDACTED] and went to an outside facility on Monday's Wednesday's and Friday's for [REDACTED] treatment.</p> <p>On 6/11/13 at 11:42 a.m., during an interview,</p>	F 281	IDR AMENDED	

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F 281	<p>Continued From page 17</p> <p>Resident #294 stated "I used to take [REDACTED] (medication used to treat [REDACTED]) and [REDACTED] (a [REDACTED] medication) and when I think everything is settled I do not get the medication that I want."</p> <p>Review of the record revealed a physician's order dated 6/5/13 for [REDACTED] 5mg three times a day as needed that had not been carried over onto the medication administration record (MAR) to direct staff to give the medication when needed.</p> <p>Review of the nursing progress note dated 6/6/13 with a time of 11:12 a.m., documented, in part; the resident stated that he needed to take [REDACTED] related to cramping at [REDACTED] per his medical doctor.</p> <p>Further review of the record revealed an un-timed physician's order dated 6/6/13 for [REDACTED] 10 mg two times a day as needed.</p> <p>On 6/17/13 at 4:45 p.m., during an interview, Staff AA confirmed that the order for [REDACTED] 5mg three times a day as needed had not been carried over onto the MAR to direct staff to give the medication when needed.</p> <p>According to the MAR, Resident #294 did not receive the original order of [REDACTED] 5mg as needed, but did receive [REDACTED] 10mg as needed, but only after the resident told the nursing staff that he should have the medication. This failure placed the resident at risk to not receive the medication according to the physician's order.</p> <p>Refer to F333,</p>	F 281	<b>IDR AMENDED</b>		

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F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to provide necessary care and services related to assessment and monitoring of non-pressure skin conditions and/or pain for 3 of 6 Sampled Residents (#s 86, 291 &amp; 294) reviewed for pain and/or skin conditions out of the 47 residents who were included in the Stage 2 review. These failures placed residents at potential risk for decline in condition or lack of timely staff response to changes in condition.</p> <p>Findings include:</p> <p>RESIDENT #86 A hospital record for Resident #86 dated 7/11/11 documented the resident had [REDACTED], [REDACTED], in the past received treatment at a specialty wound clinic for the ulcers and had a history of infections to both feet.</p>	F 309		

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F 309	<p>Continued From page 19</p> <p>The resident's record identified the resident went to the hospital in April 2013 and re-admitted to the facility on [REDACTED] 13.</p> <p>On 6/17/13 at 9:30 a.m. Staff F reported Resident #86 had a diagnosis of [REDACTED] and [REDACTED] that were the same ulcers noted in prior hospital records. Staff F also reported the resident became ill recently, went to the hospital and returned to the facility on [REDACTED] 13. Staff F also reported ulcers were slowly responding to treatment.</p> <p>A nursing admission assessment documented on a facility form titled "Nursing Data Collection Tool" completed the day of re-admission on [REDACTED] 13, contained a picture of a human body. Notations on the bodily image identified the resident had [REDACTED] on [REDACTED] at the time of re-admission. The record did not identify the location/s, descriptions or measurements of [REDACTED]s when Resident #86 returned to the facility.</p> <p>An annual Minimum Data Set Assessment (MDS, a required assessment tool) dated 6/24/12 identified Resident #86 had three venous and arterial ulcers. An MDS Care Area Assessment for pressure ulcers identified the resident continued to have a diabetic ulcer on the foot and vascular ulcers on lower extremities. Care plan consideration identified the need to proceed to plan of care for resolution of vascular ulcers.</p> <p>On 6/17/13 at 12:22 p.m. Resident #86 lay in bed with bandages on both lower legs. Staff U removed the bandages and revealed multiple non pressure skin conditions. Resident #86 had</p>	F 309			

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F 309	<p>Continued From page 20</p> <p>multiple skin concerns on the left leg that included an area of discoloration, a small red spot on the second toe and great toe and a small open, pink colored open area on the bottom of the foot. Staff U reported "I don't remember seeing two spots" on toes.</p> <p>The resident's right foot had small scabs on the end of the second and third toes and healing wounds on the right lower shin and top of the foot.</p> <p>On 6/17/13 at 12:52 p.m. Staff B reported nursing staff looked at Resident #86's skin weekly and the resident had treatments ordered for both lower extremities. Staff B also reported if there were changes the staff would notify the physician and if new skin ulcers developed they should be added to the treatment record.</p> <p>On 6/18/13 at 9:22 a.m. Staff B looked at the resident's legs and reported the resident developed a new blister on a foot yesterday. Staff B also reported large ulcers should be documented on skin sheets.</p> <p>Resident #86's medical record did not contain evidence staff identified the location, description or measurements of Resident #86's vascular ulcers at the time of readmission on [REDACTED] 13 or documented their condition on a regular basis. The record did not contain tracking information to determine if current ulcers observed were the same ulcers the resident had at the time of readmission or how and if they improved or declined in condition or if new areas of concern had developed.</p> <p>On 6/19/13 at 8:30 a.m. Staff F reviewed the</p>	F 309	<p style="text-align: right;"><b>IDR AMENDED</b></p>	

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F 309	<p>Continued From page 21</p> <p>resident's nursing admission records with the surveyor. When asked how staff identified and monitored the condition of lower extremity ulcers Staff B reported they were assessed visually and monitored each week by nursing staff. Staff F also reported when Resident #86 returned from the hospital, any documentation the facility had regarding the resident's lower extremity ulcers were documented on treatment sheets and were not transferred to skin sheets.</p> <p>Current Treatment Sheets and weekly skin assessments did not contain specific identification of location or monitoring the condition of venous ulcers or the resident's lower extremities. Resident #86's record did not contain a specific plan of care that identified bilateral lower leg vascular ulcers that included measurable goals for improvement and interventions for treatment or prevention measures in place for prevention.</p> <p>Failure to specifically identify all ulcers, dates of onset, detailed description (appearance) of ulcers, identify care interventions for treatment and response to treatment, had the potential for all staff to not know if and when the Resident #86 developed new ulcers, if previously identified ulcers improved or declined in condition with current treatment or timely identify if treatment changes were needed. Failure to document detailed information regarding each leg ulcer prevented new staff or staff not familiar with the resident's history to not have information available necessary to conduct assessment, analyze care provided and/or timely identify and respond to changes in condition.</p>	F 309	<p style="text-align: right;"><b>IDR AMENDED</b></p>	

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F 309	<p>Continued From page 22</p> <p><b>RESIDENT #291-PAIN</b> Resident #291 admitted to the facility on [REDACTED]/13 with diagnosis to include [REDACTED] which had spread to several areas including into his/her [REDACTED].</p> <p>Observations on 6/11/13 at 2:45 p.m. revealed a frail appearing resident sitting a wheelchair. During an interview at that time Resident #291 reported he/she had back pain related to his/her [REDACTED] diagnosis.</p> <p>Review of Resident #291's record revealed he/she had admitted from the hospital where he/she had gone to treat his/her back pain. The hospital records indicated while treating his/her back pain it was discovered the pain was related to [REDACTED]. Resident #291 was receiving three types of [REDACTED] medication.</p> <p>During a second interview on 6/19/13 at 9:30 a.m. Resident #291 reported her pain is worse at night, and becomes worse with movement. He/she further reported her pain level in the evening is usually 5 to 6, it can get worse but for the most part remains 5-6.</p> <p>Review of Resident #291's Minimum Data Set (MDS- an assessment tool used by the facility) date 6/10/13 revealed a pain assessment interview, section J, where the resident was asked to rate her pain on a scale from 1 to 10, with 10 being the worst pain you could imagine, over the last 5 days. Resident #291 reported her pain level to be 6.</p> <p>Resident #291 had three additional pain assessments on 5/8/13, 5/31/13, and on 6/8/13. All three assessments identify Resident #291 as</p>	F 309	<p style="text-align: right;"><b>IDR AMENDED</b></p>	
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F 309	<p>Continued From page 23 being currently in pain. All three assessments identified him/her as being at risk for pain and had experienced pain.</p> <p>The three assessments had a section to be completed which identified if the resident had reported having pain. All three were blank. There was no evidence the staff had asked Resident #291 if he/she had pain. Further review of the pain assessment flow sheet reveal a section titled "Total Pain Score," which had been left blank. At the bottom of the page was a section to be filled out that asked the resident if their current pain regimen had been effective for pain relief. Two of the three assessments had left the question blank.</p> <p>Review of the facility policy entitled Pain Management Protocol indicated that if a resident is identified as having pain staff should monitor and document the effectiveness of the pain on the Pain Management Flow Sheet and/or Medication Administration Record (MAR).</p> <p>Review of Resident #291's June 21, 2013 MAR revealed a Pain Flow Sheet. There was no documentation on the flow sheet.</p> <p>Further review of the MAR revealed an order for a [REDACTED] medication to been given as needed. The medication was to be administered after doing a pain assessment. If the resident reported having a pain level of 1-5, then only half of the tablet should be administered. If the pain was rated 6-10 then a whole tablet should have been administered. The MAR had nurses initials documented on 6/4/12, and on 6/11/12, indicating the medication had been administered to Resident #291. The MAR did not have</p>	F 309	<p style="text-align: right;"><b>IDR AMENDED</b></p>	

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F 309	<p>Continued From page 24</p> <p>documentation to show if half of the tablet had been given, or all of it. The MAR also did not have documentation to support the pain level had been assessed.</p> <p>During an interview on 6/18/13 at 10:30 a.m. Staff M reviewed the MAR and confirmed there was not documentation that identified what the resident's pain level was or how much medication was used to treat the pain. Staff M further confirmed both the pain level and the amount of medication should have been identified on the MAR.</p> <p>Review of Resident #291's care plan dated 5/28/13 identified him/her as being at risk for pain. Interventions included monitoring pain intensity after administering medication, and to reassess the effectiveness of the pain management.</p> <p>Failure to assess, reassess and document Resident #291 s reported pain levels, how it was treated, and how effective the treatment was, placed Resident #291 at potential risk for experiencing unrelieved pain, delayed treatment for pain, and failure to identify the most effective treatments.</p> <p><b>RESIDENT #291- PREVENTING SKIN BREAKDOWN</b></p> <p>Review of Resident #291's medical record revealed four Braden Skin assessments dated 5/28/13, 6/4/13, 6/11/13 and 6/18/13. All four assessments identified Resident #291 as being at risk for developing a pressure sore.</p> <p>Review of Resident #291's care plan dated 5/28/13 revealed he/she was care planned for</p>	F 309	<p style="text-align: right;"><b>IDR AMENDED</b></p>	
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F 309	<p>Continued From page 25</p> <p>being at risk for skin break down. Interventions included in the care plan included having the resident wear protective cushioned boots while in bed. Review of the care directives for Resident #291 revealed directives for staff to ensure he/she wore the protective boots while in bed.</p> <p>During an interview on 6/18/13 at 8:40 a.m. Staff BB reported when protective boots are to provided they are listed on the Medication Administration Record (MAR) for the monitoring of wearing the boots.</p> <p>Review of the June 2013 MAR revealed no documentation related to Resident #291 wearing protective boots.</p> <p>During an interview on 6/18/13 at 1:30 p.m. Staff L reported nursing assistant check the care directives to ensure they provide the care as directed in care plan.</p> <p>Observations on 6/18/13 at 1:25 p.m. revealed Resident #291 in bed without the protective boots. The protective boots were sitting in the corner of the room.</p> <p>Observations on 6/19/13 at 7:30 a.m. revealed Resident #291 in bed, without any protective boots. There was protective boots in the resident's room during the observations.</p> <p>During an interview on 6/19/13 at 9:30 a.m. Resident #291 reported she had worn the boots one time, but did not like them, so had not worn them since.</p> <p>Review of Resident #291's record revealed no documentation of refusals to wear the heel</p>	F 309	<p style="text-align: right;"><b>IDR AMENDED</b></p>	

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F 309	<p>Continued From page 26</p> <p>protectors. The facility was not able to produce any documentation of Resident #291 refusing to wear the boots.</p> <p><b>RESIDENT #291 SKIN MONITORING</b> Observations on 6/19/13 at 9:30 a.m. revealed Resident #291 had a large bandage covering her left elbow.</p> <p>Review of Resident #291's admitting assessment dated [REDACTED] 13 revealed no documentation to evidence he/she had any type of skin issue on the backside of his/her elbows. Three days later, on 5/31/13, Resident #291 had another skin assessment that indicated he/she had scabs on the backside of both elbows. The scabs were documented as "scab (old/healing)." The note did not give any other description such as size or color of the scabs.</p> <p>Review of the facility policy for skin assessment revealed a licensed nurse is to monitor skin weekly and document any changes in skin on the weekly skin integrity sheet.</p> <p>Review of the weekly skin integrity sheet revealed two assessments had been done since the 5/31/13 assessment that identified both elbows as being scabbed.</p> <p>The skin sheet dated 6/2/13, two days later, had a circle around the left elbow. Documentation indicated there was an ulcer on the left elbow; however, there was a handwritten line through the documentation through the documentation. There was not any other documentation to show what type of skin condition was identified on Resident #291's left elbow. The skin sheet did not identify any skin concern on the resident's</p>	F 309	<p style="text-align: right;"><b>IDR AMENDED</b></p>	
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F 309	<p>Continued From page 27 right elbow.</p> <p>The next skin assessment dated 6/11/13, indicated there was an "OA" (open area) on Resident #291's left elbow. The skin sheet did not indicate the size or depth of the open area. Instructions on the skin sheet direct staff that if there is an open area, then to proceed to the appropriate skin condition record. There was no evidence in the resident's record of another skin condition record.</p> <p>Failure to track the characteristics such as size and color of skin conditions placed Resident #291 at potential risk for delayed identification of skin healing problems.</p> <p><b>RESIDENT #294</b> Resident #294 admitted to the facility on [REDACTED] 13 with multiple diagnoses to include [REDACTED] and was taking multiple medications to include [REDACTED] medications, [REDACTED] 75 milligrams (mg) daily and [REDACTED] 81 mg daily.</p> <p>On 6/17/13 at 1:33 p.m., interview with Staff B reported if a resident is admitted with a bruise or skin tear, or other skin issues it is monitored daily on the Treatment Administration Record (TAR) until resolved.</p> <p>Review of the facility's nursing skin assessment dated 6/5/13 revealed a diagram of the body which documented several bruised or reddened areas. The skin assessment revealed the</p>	F 309			

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F 309	Continued From page 28 resident admitted with a reddened area to the buttocks which measured 2.9x 1.6 centimeters, an unmeasured bruise to the right leg, and an unmeasured bruise to the resident's left antecubital (region of the arm in front of the elbow).  The resident went to the hospital during survey, and observations of skin impairments did not occur.  During the same interview, when asked if the reddened area to the resident's buttocks identified on the nursing skin assessment had been pressure related, Staff B stated the reddened area on the buttocks was [REDACTED] (a type of [REDACTED]). Staff B did not provide documented evidence that the area was either a [REDACTED] infection or pressure related, and unable to provide documentation that the area had been monitored or treated.  Failure to accurately document the condition of Resident #294's skin, measure and monitor bruises and possible pressure sore, placed these residents at risk for delayed healing and/ or the development of new bruises or pressure sores.	F 309			
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION  Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318		IDR AMENDED	

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F 318	<p>Continued From page 29</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review, it was determined that the facility failed to consistently provide nursing restorative services for 1 of 2 Sampled Residents (#62) reviewed for range of motion of the 47 Sampled residents who were included in the Stage 2 review. This failure placed Resident #62 at potential risk for a decline in range of motion.</p> <p>Findings include:</p> <p>On 6/14/13 at 7:26 a.m. and at 8:12 a.m. Resident #62 was seated in a wheel chair. The resident was wearing bilateral lower extremity splints. The resident was not wearing bilateral upper extremity splints.</p> <p>On 6/14/13 at 10:43 a.m. the resident was not wearing bilateral upper extremity splints.</p> <p>On 6/14/ 13 at 11:20 am Staff O, reported Resident #62 was to wear bilateral lower extremity splints when up in a wheel chair.</p> <p>On 6/14/13 at 11:43 a.m. Staff O reported the resident is on a restorative program for splint care.</p> <p>Review of Resident #62's record noted the resident was on a nursing restorative program consisting of passive range of motion (PROM) to bilateral upper and lower extremities, splint application to bilateral upper and lower extremities with skin care before and after splint</p>	F 318	<p style="text-align: right;"><b>IDR AMENDED</b></p>	

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F 318	<p>Continued From page 30 application 6 times a week.</p> <p>Review of the resident's nursing restorative flow record for June 2013 noted the resident was to wear bilateral upper extremities splints for a total of 6 hours daily along with PROM to bilateral upper extremities for 15 minutes 6 times a week. Bilateral lower extremity splints were to be worn for a total of 4 hours 6 times a week. The resident was to have bilateral lower extremity PROM 6 days a week.</p> <p>Review of the June 2013 restorative nursing flow sheet between June 1, 2013 and June 12, 2013 noted Resident #62 did not receive his/her restorative care on 6/13/13 because the restorative aid was pulled to provide care to other residents. On 6/1/13 documentation showed the resident did not receive restorative care because he/she had to wait for a shower.</p> <p>Review of the May 2013 restorative nursing flow sheet noted Resident #62 did not receive his/her restorative care because the restorative aid was not on duty on 5/5/13, 5/12/13 and 5/20/13; the restorative aid was pulled to provide care for other residents on 5/17/13, 5/18/13, 5/22/13, 5/23/13 and 5/24/13 and because the resident waited to be showered on 5/1/13, 5/8/13; 5/29/13 and 5/31/13.</p> <p>Review of the April 2013 restorative nursing flow sheet noted Resident #62 did not receive his/her restorative care because the restorative aid was pulled to provide care to other residents on 4/21/13 and 4/25/13 and because the resident waited for a shower 4/13/13 and 4/27/13.</p> <p>Review of the March 2013 restorative nursing</p>	F 318			

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F 318	<p>Continued From page 31</p> <p>flow sheets noted Resident #62 did not receive his/her restorative care because the restorative aid was pulled to provide care to other residents on 3/25/13 and 3/26/13 and because the resident waited for a shower on 3/2/13, 3/16/13 and 3/20/13.</p> <p>Restorative nursing flow sheets for March 2013; April 2013; May 2013 and June 2013 identified the resident also refused care.</p> <p>On 6/14/13 at 10:44 a.m. Staff P reported Resident #62 is to wear bilateral lower extremity splints when seated in a wheel chair. Staff P reported the resident is to receive nursing restorative 6 times a week. Staff P reported the resident's splints are ordered for 6 days a week for 6 hours a day, but currently the resident has been refusing splints. Staff P reported the restorative staff are sometimes pulled to provide care for other residents and when that happens the restorative care does not get done.</p> <p>On 6/14/13 at 12:21 p.m. and on 6/18/13 at 8:44 a.m. Staff Q reported she is notified when restorative aids are pulled to provide care for other residents in the facility and on those days the restorative care does not get done.</p> <p>On 6/14/13 at 12:53 p.m. Resident #62 confirmed he/she does sometimes refuse restorative care.</p> <p>Review of an occupational therapy evaluation dated 6/18/13 noted no decline in the resident's range of motion.</p> <p>On 6/20/13 at approximately 10:00 a.m. Staff A, Staff B and Staff M were briefed Resident #62 did not consistently receive his/her nursing</p>	F 318	<p style="text-align: right;"><b>IDR AMENDED</b></p>	

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F 318	Continued From page 32 restorative program because restorative staff not being on duty, or restorative staff were pulled to provide care of other resident and/or the resident had to wait for a shower.  On 6/21/13 at approximately 9:40 a.m. Staff A, Staff B and Staff M did not provide further evidence Resident #62 received his/her nursing restorative program for March 2013, April 2013, May 2013 and June 2013 other than what was documented on the resident's nursing restorative program flow sheets.  Although, currently, Resident #62 did not demonstrate a decline in range of motion, the facility's failure to consistently provide nursing restorative care as outlined in the resident's plan of care placed the resident at potential risk for a decline in range of motion.	F 318		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition	F 329		

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F 329	<p>Continued From page 33</p> <p>as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to monitor 3 of 10 Sampled Residents (#s 93, 119 &amp; 295) , who were reviewed for medication use, for the effectiveness of medications used for sleep and/or pain control out of the 47 residents who were included in the Stage 2 review. This failure placed residents at potential risk for not having effective pain management and/or receiving an unnecessary medication.</p> <p>Findings include:</p> <p><b>MONITORING OF A CONTROLLED NARCOTIC ANALGESIC MEDICATION.</b> <b>RESIDENT #295</b> Resident #295 was admitted on [REDACTED] 13 for rehabilitation care following a [REDACTED] On 6/13/13 at 11:38 a.m. Resident #295 was ambulating using a walker with physical therapy.</p> <p>A medication administration record (MAR) is used by licensed staff to document all medications given to the resident. Each physician's order is listed on the front page of the MAR. When licensed staff give the resident a medication, they</p>	F 329	<b>IDR AMENDED</b>	

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F 329	<p>Continued From page 34</p> <p>initial in a square under a specific day of the month on the front page of the MAR indicating the medication was administered to the resident.</p> <p>Resident #295's pain medications are documented and monitored a form titled: "Pain Flow Sheet", a document contained in the resident's MAR. The "Pain Flow Sheet" is used by licensed staff to monitor the effectiveness of the resident's pain medication by documenting what date and time of the resident's complaint of pain, what site/location of pain, type of pain, current intensity of pain, precipitating aggravating factors contributing to pain, non-medication interventions, name of the medication and dose, intensity of pain after the pain medication is given and side effects(s), if any, of the pain medication given.</p> <p>Review of the Resident #295's MAR for June 2013 between the dates of 6/8/13 and 6/18/13 noted 37 doses of a controlled [REDACTED] medication were administered to the resident. Review of the June 2013 "Pain Flow Sheet" noted licensed staff did not document 15 out of 37 doses administered to the resident's on the resident's "Pain Flow Sheet" or any other form contained in the June 2013 MAR. By not documenting these 15 doses of medication given to the resident, licensed staff were unable to demonstrate the characteristics of the resident's pain at the time this medication was given or if the doses of medications given were effective in controlling the resident's pain. Two additional times (6/10/13 at 11:00 a.m. and 6/13/13 at 7:50 a.m.) licensed staff documented on the Pain Flow Sheet they administered this medication for the resident's complaint of pain but did not evaluate</p>	F 329	<p style="text-align: right;"><b>IDR AMENDED</b></p>	

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F 329	<p>Continued From page 35</p> <p>their effectiveness in controlling the resident's pain.</p> <p>On 6/14/13 at 8:19 a.m. Resident #295 reported satisfaction with her current medication regime.</p> <p>On 6/18/13 at 8:19 a.m. Staff B and Staff M were briefed on the lack of monitoring of the effectiveness of Resident #295's controlled medication used for pain for June 2013.</p> <p>Even though Resident #295 voiced satisfaction with his/her current medication regime, the facility's failure to monitor Resident #295's medication used to control pain, placed the resident at potential risk for having less than optimal pain control.</p> <p>Refer to F281 Resident #295 for failure to follow professional standards of conduct.</p> <p><b>RESIDENT #119</b></p> <p>On 6/13/13 at 8:45 a.m. Resident #119 reported not having any issues with his/her current medications.</p> <p>On 6/12/13 at 12:08 p.m. during an interview Resident #119 reported if the pain gets bad they will give you medication.</p> <p>Review of the Resident 119's May 2013 (MAR) noted 17 doses of a controlled [REDACTED] were initialed by licensed staff as given to the resident for pain. Five (5) doses of this medication were not documented on the resident "Pain Flow Sheet" or any other section of the May 2013 MAR. By not documenting these 5 doses of medication given to the resident,</p>	F 329	<p style="text-align: right;"><b>IDR AMENDED</b></p>	

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F 329	<p>Continued From page 36</p> <p>licensed staff were unable to demonstrate the characteristics of the resident's pain at the time the medication was given or if the doses of medications given were effective in controlling the resident's pain. Four additional doses were documented as given by licensed staff (5/14/13 at 4:30 a.m.; 5/16/13 at 4:00 a.m.; 5/18/13 at 4:00 p.m. and 5/19/13 at 5:00 a.m.) but were not monitored for their effectiveness in controlling the resident's pain.</p> <p>Review of the resident's June 2013 MAR noted 6 of 10 doses (6/1/13; 6/5/13; 6/6/13; 6/8/213; 6/9/13 and 6/12/13) of a controlled [REDACTED] medication were not documented by licensed staff on the June 2013 Pain Flow Sheet or any other section of the June 2013 MAR. By not documenting these 6 doses of medication given to the resident, licensed staff were unable to demonstrate the characteristics of the resident's pain at the time the medication was given or if the doses of medications given were effective in controlling the resident's pain.</p> <p>Even though Resident #119 voiced satisfaction with his/her current medication regime, the facility's failure to monitor Resident #119's medication used to control pain, placed the resident at potential risk for having less than optimal pain control.</p> <p>Refer to F281 Resident #119 for failure to follow professional standards of conduct. Refer to F333 Resident #119 for significant medication errors.</p> <p>MONITORING OF A PRESCRIBED SUPPLEMENT FOR INSOMNIA RESIDENT #93</p>	F 329	<p style="text-align: right;"><b>IDR AMENDED</b></p>	

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F 329	<p>Continued From page 37</p> <p>On 6/14/13 at 7:34 a.m. Resident #93 was seated in a wheel chair in her room. The resident was watching television and was very sleepy.</p> <p>Review of Resident #93's physician orders noted an order dated 7/3/12 for a prescribed supplement to be administered daily at bedtime for [REDACTED].</p> <p>On 6/19/13 at 9:17 a.m. Staff Q reported documentation of monitoring the effectiveness of the resident's prescribed supplement for sleep would be on a tracking form, a part of the medication administration record (MAR). Staff Q and the surveyor reviewed the resident's MAR(s) for May 2013 and June 2013. Staff Q agreed there was no monitoring of effectiveness of Resident #93's supplement for [REDACTED] on the May 2013 MAR and on the June 2013 MAR. Staff Q reported she/he will initiate a tracking sheet today.</p> <p>Failure to monitor Resident #93's prescribed supplement used for [REDACTED] placed the resident at potential risk for receiving a supplement that was not effective in helping the resident obtain sleep.</p> <p>On 6/20/13 at approximately 10:00 a.m. Staff A, Staff B and Staff M were briefed the controlled [REDACTED] medication was not consistently monitored for effectiveness for Resident #119 and Resident #295 and Resident #93's prescribed supplement for [REDACTED] was not monitored for effectiveness during May 2013 and June 2013.</p> <p>On 6/21/13 at approximately 9:40 a.m. Staff A, Staff B and Staff M did not provide further</p>	F 329	<p style="text-align: right;">IDR AMENDED</p>	
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F 329	Continued From page 38 evidence of drug monitoring for Resident #119 and #295 or further evidence of supplement monitoring for Resident #93.  Refer to F281 Resident #93 for failure to follow professional standards of conduct.	F 329		
F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure medication regimens were free from significant medication errors for 6 of 13 Sampled Residents (#s 119, 155, 158, 263, 293, 294, & 56) reviewed for either unnecessary medication use or pain of the 47 residents who were included in the Stage 2 review. This failure had the potential to place residents at risk to not achieve consistent optimal blood sugar levels and/or pain control and placed all residents at risk for adverse effects from their medications.  Findings include:  Two different systems (Prandial Protocol and Mathematical Formula System) were being used to determine the amount of insulin to be given based on the resident's blood sugar levels.  1. The Prandial Protocol system required staff to administer a pre-determined dose of insulin at	F 333	IDR AMENDED	

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F 333

Continued From page 39  
breakfast, lunch and dinner. In addition, staff adjusted the level of insulin by adding or subtracting the number of units of insulin based on the resident's blood sugar level. At bedtime staff administered the number of units ordered by the physician based on the resident blood sugar levels.

2. A different system required use of a mathematical formula of subtraction and dividing from the blood sugar level to determine the units of insulin to be administered.

**INSULIN ADMINISTRATION**

**RESIDENT #119**  
Resident #119 had orders for the Prandial Protocol to be used to determine the amount of [REDACTED] to be administered.

On 6/12/13 at approximately 12:00 noon Resident #119 was using an electric wheel chair to move through the halls of the facility and interacting with staff and other residents.

Review of Resident #119's June 2013 Medication Administration Record (MAR) noted the following insulin medication errors:

For breakfast: On 6/2/13 1 unit was ordered 2 units were given; on 6/6/13 1 unit was ordered 2 units were given; on 6/9/13 3 units were given 5 units were ordered.

For lunch: On 6/10/13 5 units given 6 units were ordered. On 6/11/13 5 units were given 6 units were ordered.

For dinner: Additional [REDACTED] medication errors

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F 333

Continued From page 40 were noted on 6/5/13 and 6/7/13.

At hour of sleep (HS): Additional [REDACTED] administration errors were noted on 6/2/13, 6/4/13 and 6/9/13.

Review of Resident #119's May 2013 Medication Administration Record (MAR) noted the following [REDACTED] errors.

For breakfast: On 5/17/13 2 units were given 1 unit was ordered; on 5/18/13 3 units were given 2 units were ordered.

For lunch: On 5/1/13 6 units given 3 units ordered; on 5/2/13 5 units were given 6 units ordered; On 5/3/13 8 units were given 15 units ordered; on 5/20/13 5 units given 6 units ordered; on 5/29/13 5 units given 6 units ordered.

For dinner: Additional [REDACTED] administration errors were noted on 5/4/13; 5/18/13 and 5/22/13.

At HS: Additional [REDACTED] administration errors were noted on 5/2/13; 5/9/13 and 5/23/13.

On 6/18/13 at 11:15 a.m. Staff M agreed there were errors on the Resident #119's June 2013 MAR.

On 6/19/13 at 8:41 a.m. Staff Q was briefed on the [REDACTED] errors on Resident #119's MAR(s) for May 2013 and June 2013.

Refer to F281 Resident #119 for failure of licensed nurses to administer [REDACTED] as ordered by the physician.

**RESIDENT #158**

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F 333	<p>Continued From page 41</p> <p>Resident #58 had orders for the Prandial Protocol to be used to determine the amount of [REDACTED] to be administered.</p> <p>Review of Resident #158's June 2013 Medication Administration Record (MAR) noted the following insulin medication errors:</p> <p>For breakfast: On 6/3/13 6 units were given 10 units were ordered; on 6/4/13 5 units were given 8 units were ordered;</p> <p>For lunch: Additional insulin administration errors were noted on 6/4/13.</p> <p>For dinner: Additional insulin administration errors were noted on 6/13/13.</p> <p>At HS: Additional insulin administration errors were noted on 6/7/13, 6/8/13 and 6/13/13.</p> <p>Review of Resident #158's May 2013 Medication Administration Record (MAR) noted the following insulin medication errors:</p> <p>For breakfast: Additional insulin medication errors were noted on 5/3/13, 5/13/13, 5/14/13, 5/16/13, 5/17/13 and 5/18/13.</p> <p>For lunch: Additional insulin medication errors were noted on 5/3/13 and 5/26/13.</p> <p>For dinner: Additional insulin medication errors were noted on 5/1/13; 5/2/13; 5/4/13</p> <p>At HS: Additional insulin medication errors were noted on 5/1/13; 5/4/13, 5/8/13, 5/9/13, 5/10/13,</p>	F 333	<p style="text-align: right;"><b>IDR AMENDED</b></p>	

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F 333	<p>Continued From page 42 5/13/13, 5/15/13, 5/19/13, 5/23/13, 5/24/13, 5/27/13, 5/28/13 and 5/29/13.</p> <p>On 6/20/13 at approximately 10:00 a.m. Staff A, Staff B and Staff M were briefed Resident #119 and Resident #158 had multiple insulin errors for May 2013 and June 2013.</p> <p>On 6/21/13 at approximately 9:40 a.m. Staff A, Staff B and Staff M did not provide evidence Resident #119 and Resident #158 were free of insulin errors for the months of May 2013 and June 2013.</p> <p>Refer to F281 Resident #158 for failure of licensed nurses to administer insulin as ordered by the physician.</p> <p>RESIDENT #155 A quarterly Minimum Data Set Assessment (MDS, assessment tool) identified Resident #155 admitted to the facility on [REDACTED]/12 with diagnoses that included [REDACTED]</p> <p>A physician order dated 4/8/13 contained specific orders for staff to administer insulin at breakfast, lunch, dinner and at bedtime. The amount of insulin the physician ordered varied depending on the resident's blood glucose level. After staff checked the resident's blood glucose level at mealttime, the physician ordered 2 units of insulin given for a blood glucose level of 101 to 150 and above. In addition, staff added or subtracted insulin units to the two units of insulin already ordered, when the blood glucose level was 100 or below or above 151.</p> <p>Separate orders were written for bedtime (HS) insulin administration that included 1 unit of</p>	F 333	<p style="text-align: right;"><b>IDR AMENDED</b></p>	

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F 333	<p>Continued From page 43</p> <p>insulin for a blood glucose level of 201 to 250.</p> <p><b>MAY 2013 MEDICATION ERRORS AT 4:00 P.M.</b> The May 2013 medication insulin record (MAR) documented at 4:00 p.m. Resident #155 had a blood glucose level of 131 on 5/7/13 and 138 on 5/12/13. Staff documented they did not administer 2 units of insulin as indicated on the prandial protocol.</p> <p>On 5/22/13 staff documented Resident #155 had a glucose level of 200 and administered four units of insulin and not three units per the prandial protocol.</p> <p>On 5/31/13 staff documented on the MAR the resident's blood sugar was 162 and administered 2 units of insulin and not three units per the prandial protocol. Physician prandial orders directed staff to add one additional unit of insulin for a glucose level between 151 and 200.</p> <p><b>MAY 2013 MEDICATION ERRORS AT 11:30 A.M.</b></p> <p>On 5/30/13 at 11:30 a.m. staff documented Resident #155 had a blood glucose level of 156. Physician orders directed staff to add one additional unit of insulin for a glucose level of 151 to 200 in addition to the two units in the standing order. Staff documented they administered only 2 units of insulin instead of 3 units ordered in the prandial protocol.</p> <p><b>MAY 2013 MEDICATION ERRORS HS</b></p> <p>On 5/18/13 at 8:00 p.m. staff documented they administered 2 units of insulin for a blood glucose level of 211. Physician orders directed staff to administer 1 unit of insulin at HS for blood</p>	F 333			

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F 333	<p>Continued From page 44 . glucose levels of 201 to 250.</p> <p>On 6/14/13 at 8:28 a.m. Staff CC reported resident MARs were reviewed weekly. When asked if errors in dosing insulin were found, Staff CC reported more of a concern nursing staff documented information on the wrong line on the MAR.</p> <p>The facility failed to ensure licensed staff consistently administered the correct dose of insulin the physician ordered. This resulted in significant medication errors due to frequency of errors and increased potential adverse response, such as hypoglycemia or hyperglycemia from incorrectly dosing insulin.</p> <p>Refer to F 281 for failure to follow physician orders.</p> <p><b>FENTANYL PATCH FOR RESIDENT #293</b> The facility admission record identified Resident #293, age [REDACTED], admitted to the facility on [REDACTED]/13. A physician note on a History &amp; Physical form dated 6/4/13 indicated the resident had a diagnosis of [REDACTED] with [REDACTED].</p> <p>Physician orders dated 6/6/13 directed licensed staff to administer a 25 microgram (mcg) [REDACTED] patch and to change it every three days to treat Resident #293's chronic pain.</p> <p>[REDACTED] patches are a potent medicated controlled substance used in chronic pain management. The patch works by slowly releasing medication into the bloodstream over 48 to 72 hours, allowing for long-lasting relief from pain. After three days of application, a considerable amount of medication can still</p>	F 333		

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F 333	<p>Continued From page 45</p> <p>remain on the patch and continue to be released. Staff needed to take special precautions to remove previously applied fentanyl patches before applying a new one every three days to ensure a more consistent dosing absorption.</p> <p>On 6/13/13 at 7:23 a.m. Staff DD reported the physician increased the dose of [REDACTED] patch from 25 mcg to 50 mcg on 6/12/13. Staff DD entered the resident's room at this time to look for placement of patch/s applied on 6/12/13. Staff F also entered the room and uncovered Resident #293's shirt in the front and the back to look for patch placement. The resident had two patches on the front chest dated 6/12/13 and one patch on the upper left back dated 6/9/13.</p> <p>Staff DD reviewed the medication record with the surveyor and reported staff documented they applied a 25 mcg patch on 6/9/13 on the left back and a 50 mcg patch on the left upper chest on 6/12/13. The surveyor requested clarification of the dose of each of the two patches applied to Resident #293's front chest.</p> <p>On 6/12/13 at 7:46 a.m. Staff F checked narcotic records and pharmacy documents and reported "we have a medication error." Staff F reported each of the two patches on the resident's front chest were 25 mcg each (a total of 50 mcg). Staff F also reported staff should have removed the 25 mcg patch (on the upper back) when they applied the 50 mcg patch.</p> <p>On a prior occasion, staff documented in a nursing note on 6/9/13 and timed 9:27 p.m., they did not locate or remove a patch on Resident #293's left chest before applying a new one. The record did not contain evidence staff reported the</p>	F 333	<b>IDR AMENDED</b>	

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F 333	<p>Continued From page 46</p> <p>██████████ patch applied three days earlier on 6/9/13 was missing either.</p> <p>During interviews conducted on 6/13/13 at 10:31 a.m. with Staff F and on 6/13/13 at 10:42 a.m. with Staff B, both reported when the nurse did not locate the patch that needed to be removed, they should have notified administration to determine what happened to it.</p> <p>The resident's record did not identify Resident #293 had an adverse reaction to the increased dose of ██████████ patches between 6/9/13 and 6/12/13 or complications related to pain when staff noted the ██████████ patch applied on 6/6/13 missing on 6/9/13.</p> <p>On 6/17/13 at 9:00 a.m. Staff B reported licensed staff received training and should have monitored ██████████ patch placement when first initiated (6/6/13) every shift. Staff did not initiate placement checks until following surveyor observations on 6/12/13.</p> <p>A drug book titled "Geriatric Dosage Handbook" 12th edition states "elderly have been found to be twice as sensitive as younger patients to the effects of ██████████." Since staff did not remove a 25 mcg patch placed on 6/9/13 before they applied a 50 mcg patch on 6/12/13, Resident #293 had a total of 75 mcg of ██████████ on the skin available for absorption and not 50 mcg as ordered resulting in a significant medication error.</p> <p>Refer to F 281 for failure to follow physician orders.</p>	F 333	<p style="text-align: center;"><b>IDR AMENDED</b></p>	

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F 333	<p>Continued From page 47</p> <p><b>RESIDENT #263</b> Resident #263 admitted to the facility on [REDACTED]/13 with diagnosis to include [REDACTED].</p> <p>Review of Resident #263's medical record revealed a physician's order dated 5/21/13 which directed staff to administer insulin injections four times daily. The amount of insulin to be injected was determined by using the following formula; blood sugar minus 100 divide by 30 equals the number of units to be given.</p> <p>Review of the May 2013 Medication Administration Record (MAR) revealed Resident #263 was given insulin at 6:30 a.m., 11:30 a.m., 4:00 p.m., and 8:00 p.m. Further review of the May 2013 MAR revealed Resident #263 had received insulin 7 times at 11:30 a.m. Of the 7 doses, 2 had been calculated wrong, and the resident received the wrong dose of insulin.</p> <p>Further review of the May 2013 MAR revealed Resident #263 had received insulin at 4:00 p.m. 8 times. Of the 8 administrations, the resident received the wrong dose one time. Resident received the wrong dose of insulin 2 out of 10 administrations at 8:00 p.m. in May.</p> <p>Review of the June 2013 MAR revealed staff had delivered the wrong dose of insulin 2 out of 7 times 8:00 a.m. There was 5 out of 11 errors in calculating the dose at 11:30 a.m. Two of 11 administrations at 11:00 a.m. were calculated incorrectly, and one of 11 doses at 8:00 p.m. were calculated incorrectly.</p> <p>Resident #263 received the wrong amount of insulin 5 times in the 10 days she was at the</p>	F 333	<p style="text-align: right;"><b>IDR AMENDED</b></p>	
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F 333 Continued From page 48 facility, and 9 times in the first 12 days of June. Failure to administer insulin as prescribed by the doctor at frequent intervals placed Resident #263 at potential risk for having seriously high or low blood sugar. This failure also placed Resident #263 at potential risk for inaccurate assessments when the physician reviews his/her blood sugars to adjust [REDACTED] dosages.

Refer to F281

**RESIDENT #294**  
Resident # 294 admitted to the facility on [REDACTED] 13 with multiple diagnoses to include [REDACTED]

Record review revealed a physician's order dated 6/5/13 which directed staff to give sliding scale insulin. The order directed staff to give sliding scale based on a formula. Blood sugars over 160 subtract 100 divide by 30 equal's number of units to give.

Review of the MAR, revealed on 6/5/13, the resident received less insulin than he should have based on the formula.

On 6/17/13 at 5:24 p.m., during an interview, Staff B did the calculations and confirmed the resident should have received more units based on the formula, and staff B stated the nurse should have rounded up in order to give the correct dose.

**RESIDENT #294**  
Resident #294 admitted to the facility on [REDACTED] 2013 with multiple diagnoses to include [REDACTED] and went to an outside facility on Monday's Wednesday's and Friday's for [REDACTED] treatment.

F 333

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F 333	<p>Continued From page 49</p> <p>On 6/11/13 at 11:42 a.m., during an interview, Resident #294 stated "I used to take [REDACTED] (medication used to treat [REDACTED]) and [REDACTED] (a [REDACTED] medication) and when I think everything is settled I do not get the medication that I want."</p> <p>Review of the record revealed a physician's order dated 6/5/13 for [REDACTED] 5mg three times a day as needed that had not been carried over onto the medication administration record (MAR) to direct staff to give the medication when needed.</p> <p>Review of the nursing progress note dated 6/6/13 with a time of 11:12 a.m., documented, in part; the resident stated that he needed to take [REDACTED] related to cramping at [REDACTED] per his medical doctor.</p> <p>Further review of the record revealed an un-timed physician's order dated 6/6/13 for [REDACTED] 10 mg two times a day as needed which had been carried over to the MAR and implemented.</p> <p>On 6/17/13 at 4:45 p.m., during an interview, Staff AA confirmed that the order for [REDACTED] 5mg three times a day as needed had not been carried over onto the MAR to direct staff to give the medication when needed.</p> <p>According to the MAR, Resident #294 did not receive the original order of [REDACTED] 5mg as needed, but did receive [REDACTED] 10mg as needed, but only after the resident told the nursing staff that he should have the medication. This failure placed the resident at risk to not receive the medication according to the physician's order.</p>	F 333	<p style="text-align: center;"><b>IDR AMENDED</b></p>	
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F 333	<p>Continued From page 50</p> <p>Refer to F281</p> <p><b>RESIDENT #56</b> Resident #56 admitted to the facility on [REDACTED]/13 with multiple diagnoses to include [REDACTED].</p> <p>Review of the record revealed a physician's order dated 5/8/13 for [REDACTED] 800mg by mouth as needed with snacks (medication that reduces blood levels of phosphorus in people with [REDACTED] who are on [REDACTED]).</p> <p>Review of May 2013 and June 2013 medication administration records (MAR) revealed the order did not get carried over onto the MAR to direct staff to give the medication when needed.</p> <p>On 6/18/13 at 8:25 a.m., during an interview, Staff AA confirmed the medication did not get carried over onto the May 2013 and June 2013 MAR's.</p> <p>Failure to carry over physician orders onto the MAR, placed the resident at risk to not receive the medication according to the physician's order.</p> <p>Refer to F281</p>	F 333		
F 441 SS=F	<p><b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b></p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p>	F 441		

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F 441	<p>Continued From page 51</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <ol style="list-style-type: none"> <li>(1) Investigates, controls, and prevents infections in the facility;</li> <li>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</li> <li>(3) Maintains a record of incidents and corrective actions related to infections.</li> </ol> <p>(b) Preventing Spread of Infection</p> <ol style="list-style-type: none"> <li>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</li> <li>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</li> <li>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</li> </ol> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to maintain infection control practices during dressing changes for 1 of 2 Sampled Resident (#86) observed for dressing changes out of the</p>	F 441	<p style="text-align: right;"><b>IDR AMENDED</b></p>	

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F 441

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47 residents who were included in the Stage 2 review. Failure to disinfect hands and change gloves between wound sites had the potential to spread an infectious agent from one wound site to another.

In addition, the facility also failed to handle laundry in a manner to prevent the spread of infection. The facility's failure to have a system in place to prevent, recognize and control the spread of infection placed residents at risk for coming into contact with disease causing germs and developing preventable infections.

Findings include:

Standard precautions are based upon the principle that all blood, body fluids, secretions, excretions, non-intact skin may contain transmissible infectious agents. Standard precautions are intended to be applied to the care of all persons in all healthcare settings regardless of the suspected or confirmed presence of an infectious agent. Appropriate infection control measures should be used in each resident interaction.

**DRESSING CHANGES**  
On 6/17/13 at 9:30 a.m. Staff F reported Resident #86 had a diagnosis of [REDACTED] and [REDACTED]. Staff F reported the resident became ill and went to the hospital and returned on [REDACTED]/13.

A "Nursing Data Collection Tool" dated [REDACTED]/13, at the time of re-admission, contained a picture of a human body. Notations identified on the bodily form the resident had [REDACTED].

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F 441	<p>Continued From page 53</p> <p>A physician order dated 6/12/13 directed staff to administer an oral antibiotic twice a day for slow healing of wounds and risk of infection.</p> <p>On 6/17/13 beginning 12:22 p.m., after removing multiple dressings from different wounds on Resident #86's lower legs, multiple ulcers and scabs on both legs were revealed. On the left leg the resident had a small open area of skin on the bottom of the left foot. Staff U reported the area was a scab and just opened up. The resident also had a healing ulcer on top of the foot.</p> <p>On the right leg, Resident #86 had multiple scabs on toes and a healing ulcer on the right shin.</p> <p>Staff U washed hands and put on a pair of gloves and sprayed a cleaning solution onto the resident's left lower leg and then the right lower leg. Staff U wiped the solution from the left leg to dry it and then wiped the right leg without first disinfecting hands and changing gloves between each leg.</p> <p>While wearing the same pair of gloves, Staff U opened a package that contained an oil emulsion non adherent dressing, removed the dressing and handled the edges it to open it up. Staff U picked up a medicated ointment and applied it to the dressing material and then covered multiple wound sites on both legs with the dressing material and covered them with a gauze dressing.</p> <p>On 6/18/13 at 9:32 a.m. Staff U reported he/she should have disinfected hands and changed gloves between different wounds.</p> <p>On 6/18/13 at 9:47 a.m. the surveyor asked Staff</p>	F 441	<p style="text-align: right;"><b>IDR AMENDED</b></p>	
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F 441	<p>Continued From page 54</p> <p>V when staff should disinfect hands and re-glove during dressing changes involving different wound sites. Staff V left to locate a facility policy related to dressing changes. When Staff V returned, Staff V reported the wound treatment guidelines only talked about changing dressings on a single wound site.</p> <p>On 6/19/13 at 8:30 a.m. Staff F reported Resident #86 received an antibiotic for wound healing and the resident's legs improved with the medication. Staff F reported the physician wanted the resident on the antibiotic to assist with healing of all wounds.</p> <p>Resident #86 received an antibiotic to aide with healing of multiple wounds. During dressing changes to multiple wound sites on the resident's legs, staff did not remove potentially contaminated gloves, disinfect hands and re-glove after handling and removing soiled dressings or before application of medicated ointment and dressings to multiple wound sites. Staff wore the same pair of gloves to apply medicated dressings to different wounds on both legs potentially cross contaminating organisms between multiple wound sites.</p> <p><b>LAUNDRY</b> On 6/18/13 between the hours of 9:30 a.m. and 10:10 a.m., observations of the laundry room procedures revealed Staff H used a clear liquid from a bucket to clean the washing machine rim with a wash rag after she placed soiled linens in the washing machine. When asked what the clear liquid was, Staff H stated it is a bleach water mixture.</p> <p>When asked how much bleach is used to</p>	F 441	<p style="text-align: center;"><b>IDR AMENDED</b></p>	

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F 441	Continued From page 55 determine if it is at a consistency to ensure sanitization, Staff H stated it is a 10:1 ratio, but Staff H has been doing it for so long she does not need to measure. When asked how the water is tested to ensure sanitization, Staff J stated, Staff H has been doing it for over 20 years and she knows by experience how much is needed.  On 6/18/13 at 2:52 p.m., Staff A confirmed the laundry staff do not have a method of testing the water for sanitization. Staff A reported she would have the staff use a premixed bottle of sanitizing solution to ensure accurate sanitization.	F 441		
F 463 SS=F	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH  The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.  This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to maintain all portions of the resident call light system in an operational condition in 4 of 4 Wings of the facility (100, 200, 300 and 400). This failure placed residents, staff and/or visitors at potential risk for not being able to summon staff for assistance if needed.  Findings include:  On 6/10/13 at 4:13 p.m. room 408's bathroom call	F 463	IDR AMENDED	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 463	<p>Continued From page 56</p> <p>light was activated and the light over the entry door of room 408 did not illuminate (light up). Room 408's bathroom call light also did not illuminate or sound at the 300-400 Wing nurses work station.</p> <p>On 6/10/13 at 4:18 p.m. Staff C, who was conducting maintenance rounds and working on other call lights on the 300 and 400 Wing, entered room 408, pulled the bathroom call light cord and the light at the entry to the resident's room did not illuminate and the light on the call panel at the 300-400 nurses station did not illuminate or make a sound. Staff C reported there is probably a problem with call cord switch in the bathroom and he/she will replace it.</p> <p>On 6/10/13 at 4:39 p.m. Staff C replaced the call light cord switch in the bathroom of room 408. The light illuminates at the room door entry and illuminates and sounds at the call light panel located at the 300-400 Wing nurses work station.</p> <p>On 6/10/13 at approximately 6:15 p.m. staff were changing the light bulb in hall from room 118. Room 118's call light registered on the call light panel but not at the door entry to room 118. Staff C was conducting maintenance rounds and checking resident call lights with other staff assistance.</p> <p>On 6/11/13 at approximately 7:45 a.m. the resident in room 408-A, who had a pneumonic (soft grey easy to push) call light, activated his/her call light and the light illuminated at the 408 door entry but did not light or sound at the call light register panel at the 300-400 nurses station. At this time the surveyors made rounds to evaluate the call lights on all wings of the</p>	F 463	<p style="text-align: right;"><b>IDR AMENDED</b></p>	

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

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OMB NO. 0938-0391

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F 463	<p>Continued From page 57 facility and found the following:</p> <p><b>100 WING</b> Room 111A did not register a light at the call light register panel at the 100-200 Wing nurses station.</p> <p>Room 111B did not register a light at the call light register panel at the 100-200 Wing nurses station.</p> <p>Room 111 bathroom did not register a light at the call light register panel at the 100-200 Wing nurses station.</p> <p>Room 118, pneumatic pad call light, did not sound at the call light register panel at the 100-200 Wing nurses work station.</p> <p><b>200 WING</b> Shower room did not light at entry door.</p> <p>Room 211A did not light or sound at the call light register panel at the 100-200 Wing nurses station.</p> <p><b>300 WING</b> Room 302 bathroom call light did not illuminate at the door entry.</p> <p>Room 303A resident bedside call light did not illuminate at entry door or at the call light register panel or sound at the call light register panel at the 300-400 Wing nurses work station.</p> <p>Room 303B resident bedside call light did not illuminate at entry door or at the call light register panel or sound at the call light register panel at</p>	F 463		

**IDR AMENDED**

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F 463	<p>Continued From page 58 the 300-400 Wing nurses work station.</p> <p>Room 303 bathroom did not illuminate at entry door or at the call light register panel or sound at the call light register panel at the 300-400 Wing nurses work station.</p> <p>Room 314B (pneumatic pad call light ) did not sound at the call light register panel at the 300-400 Wing nurses work station.</p> <p><b>400 WING</b> Room 408A, a pneumatic pad call light, light illuminated at the 408 door entry but did not light or sound at the call light register panel at the 300-400 nurses station.</p> <p>Room 409A no light at entry door and no light or sound at call light register panel.</p> <p>On 6/11/13 at 8:00 a.m. Staff C reported the pneumatic call pad in room 408A is air controlled and only activates one switch for the light. We instruct the nurses to check the call light frequently.</p> <p>On 6/11/13 at approximately 9:00 a.m. Staff AC reported audits of the facility call light systems consist of going through the whole building every week, if problem or malfunction it is fixed right away. On weekends and nights nurses have lights and tool kits, if they find a problem other than a light bulb they call and we come in and fix them. The light bulbs just burn out. They are regular light bulbs on the front hallways that have more acute care so they burn out faster, the back hall does not burn out as fast. We completed an audit of call lights on 6/10/13. Lights were</p>	F 463	<p style="text-align: right;"><b>IDR AMENDED</b></p>	

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F 463	Continued From page 59 checked room to room yesterday (6/10/13) all call lights were checked in every room. We check the whole system. Staff C reported he and Staff FF are on call. Clip boards are at each nurse station, so we have log, staff are to write it down even if the call light is fixed. On 6/11/13 at 10:53 a.m. surveyors reported their findings regarding the facility's call light system malfunctions to the field manager. On 6/11/13 at 12:15 p.m., after receiving instructions from management, a safety plan was obtained from the facility to ensure the needs of the residents would be met.	F 463			

**IDR AMENDED**

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #  <b>505324</b>	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: <b>6/21/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF PUYALLUP</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>511 10TH AVENUE SOUTHEAST PUYALLUP, WA</b>		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
<b>F 411</b>	<p><b>483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS</b></p> <p>The facility must assist residents in obtaining routine and 24-hour emergency dental care.</p> <p>A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to place Resident #294 on the dental referral list after the MD had ordered a dental consult for the resident.</p> <p style="text-align: right;"><b>IDR AMENDED</b></p>		

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

The above isolated deficiencies pose no actual harm to the residents