

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

PRINTED: 07/01/2013
FORM APPROVED
OMB NO. 0938-0391

1393

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505272	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/24/2013
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MOUNT VERNON	STREET ADDRESS, CITY, STATE, ZIP CODE 2120 EAST DIVISION STREET MOUNT VERNON, WA 98273
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F 000 INITIAL COMMENTS

F 000

This report is the result of an unannounced Quality Indicator Survey (QIS) conducted at Life Care Center of Mount Vernon on 6/17, 6/18, 6/19, 6/20, 6/21 and 6/24/13. A sample of 25 residents was selected from a census of 79. The sample included 21 current residents and the records of 4 former and/or discharged residents.

RECEIVED
JUL 12 2013
ADSA/RCS
Smokey Point

The survey was conducted by:

██████████ R.N., B.S.N.
██████████ R.N., B.S.N.
██████████ BSHS
██████████ R.N., B.S.N.
██████████ R.N., B.S.N.

The survey team is from:

Department of Social and Health Services
Aging and Long Term Support Administration
Residential Care Services, Region 3, Unit B
3906 172nd Street NE, Suite 100
Arlington, WA 98223

Telephone: (360) 651-6850
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Robert Crayford 7/1/13
Residential Care Services Date

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>Executive Director</i> 7/24/13 (X6) DATE
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to promote or protect the dignity of three residents (117, 58, and 32). In addition, the facility failed to provide a dignified dining experience for residents in the Rainier Dining Room. These failures had the potential to diminish the quality of life for these residents.</p> <p>Findings include:</p> <p>RESIDENT 117 This resident had a primary diagnosis of [REDACTED] and resided in the special care unit.</p> <p>Observations on 6/17/13 at approximately 12:10 p.m., revealed the resident was sitting at a table with 2 other residents. Resident 117 had her right leg crossed over her left leg. The resident took her sock off and started playing with her foot using her hands. The resident's sock was on the resident's lap. Staff G, a nursing assistant, brought the resident her lunch tray and observed the resident's foot and the resident's sock on her lap. The staff member did not assist the resident to put her sock back on. She put the tray in front of the resident and walked away. The resident then put her sock in the middle of the table and continued to play with her foot. Shortly after, the</p>	F 241	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</p> <p>F 241</p> <p>Correction as it relates to the resident:</p> <p>Resident 117 foot was assessed and no issues were noted. Resident was also provided with shoes to encourage to wear in the dining room and care plan was updated.</p> <p>Resident 58 the sign was removed from the wall and was decorated. Resident was interviewed and verbalized no further concerns.</p> <p>The facility obtained adjustable height stool to allow staff to sit while feeding resident 32.</p> <p>Residents in the Rainier Dining Room will be provided pre-meal hydration; residents at the same table will be served at the same time.</p> <p>The CD player was set to random to prevent repeating music from being played.</p>	7/24/13
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F 241	<p>Continued From page 2</p> <p>resident picked her spoon up and started scratching her foot with it. The resident proceeded to put the spoon in her mouth. At no time did a staff member come and assist the resident.</p> <p>RESIDENT 58 This resident admitted to the facility in [REDACTED] of 2013 for [REDACTED]. The resident was observed numerous times to be ambulating with a walker in a hallway. During an observation in the resident's room on 6/20/13 at 8:30 a.m., a large sign was posted on the wall in front of the resident's bed. It read "You are too weak to get up by yourself-ask for help." The remainder of the room was stark, with a small flower vase on a piece of furniture. When interviewed on 6/20/13 at 9:45 a.m., the resident stated she did not care for the sign posted on the wall.</p> <p>RAINIER DINING ROOM During observations on 6/17/13 at 12:15 p.m., 13 residents were observed in the dining room. They were seated 3 to 4 at a table. Most appeared to be sleeping. A staff member turned the music on at 12:17 p.m. One unidentified female resident repeated over and over, "I'm hungry." There were no beverages given to the residents and conversation was kept to a minimum between staff only. Four staff were in the dining room when the trays were delivered at 12:15 p.m. Two trays were passed in a 6 minute time frame. Beverages were given to the residents only upon the presentation of their lunch tray.</p> <p>Resident 32 was seated by herself. An overbed table was placed beside her wheel chair. Staff C, a nursing assistant was observed to stand over</p>	F 241	<p>Action taken to protect residents in similar situations:</p> <p>Room rounds were made to remove posted signs.</p> <p>Appropriate seating was obtained for staff when feeding residents who need assistance.</p> <p>CD players were reviewed to verify they were not set to the repeat function</p> <p>Measures taken or systems altered to ensure the problem does not recur:</p> <p>Staff were re-educated by the Staff Development Coordinator (SDC) on maintaining dignity including not posting signs in resident rooms, serving residents at the same table at the same time, sitting down to feed residents, to engage is resident centered conversation and to monitor resident behavior in the dining room to promote/maintain their dignity.</p> <p>Dining room staff were educated on use of the CD player functions to prevent repeating music and to offer pre-meal hydration.</p>	
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F 241	Continued From page 3 the resident upon delivery of her tray. The employee continued to stand over the seated resident and feed her until a nurse entered the room and instructed him to sit down while assisting the resident. During the remainder of the observation, not everyone seated at the same table was served at the same time. Several residents waited up to 10 minutes to be served, while their table mate was eating their meal. The last resident was served at 12:33 p.m. During observations on 6/18/13 from 7:45 a.m. to 9:11 a.m., the same song was played over and over on the dining room stereo system. While observing the dining room on 6/19/13 at 8:00 a.m., Staff D, a nursing assistant was observed standing over Resident 32, feeding her. An interview on 6/20/13 at 3:15 p.m. with the Director of Nursing Services confirmed it was the policy of the facility to have employees seated when assisting residents with their meals.	F 241	Plans to monitor performance to ensure solution is sustained: Dining room observations to monitor for dignity will be completed by the dining room supervisors weekly for three months, immediate follow up will be completed. Random room rounds will be completed weekly by the facility management team to ensure no other signs get posted. Results of the dining room observations and room rounds will be provided to the Executive Director any trends noted will be reported to the facility PI committee. Date Certain: July 24, 2013 Title of Person Responsible for Compliance: The Executive Director F 248 Correction as it relates to the resident: Resident 29 activity assessment was updated and interventions implemented on the care plan/care guide. Resident 83 activity interests were communicated to staff on special care unit. Resident 113 activity assessment and care plan were updated to include activities of interest.	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	F 248		

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F 248	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide activities for 3 (29, 83 and 113) of 3 cognitively impaired residents who were dependent on staff to provide activities to meet their leisure interests and needs. This failure did not promote the residents' mental and psychosocial well-being and placed them at risk for social isolation and a diminished quality of life.</p> <p>Findings include: RESIDENT 29 The resident was admitted to the facility on [REDACTED]/12 with diagnosis including [REDACTED]. The resident's initial activities evaluation dated 6/8/12, documented the resident was interested in walking, sing alongs, animals/pets, arts/crafts, board games, cards, baking and gardening.</p> <p>Multiple observations throughout the survey dates revealed the resident was often sitting in the living room, in front of the television. The television was on, the resident was either looking at it or had fallen asleep.</p> <p>RESIDENT 83 The resident was admitted to the facility on [REDACTED]/10, with diagnosis to include [REDACTED].</p> <p>The resident's activities assessment dated 3/25/13, documented the resident's current interests included animals, arts/crafts, gardening, sing alongs and social parties.</p>	F 248	<p>Action taken to protect residents in similar situations:</p> <p>All cognitively impaired residents have the potential to be affected. Resident care plans were audited to ensure that they have appropriate activity goals and intervention. An activity assistant was hired to assist with activities to all promote quality of life.</p> <p>Measures taken or systems altered to ensure the problem does not recur:</p> <p>Activity supplies were made available to staff working with cognitively impaired residents.</p> <p>Staff working with cognitively impaired resident were re-educated by the Activity Director on providing meaningful activities to promote their quality of life, completing assessments and care plans inclusive of residents activities of choice.</p> <p>Plans to monitor performance to ensure solution is sustained:</p> <p>Random observation of activities on the special care unit will be done weekly for three months by the Activity Director to verify that activities are provided and that the resident's quality of life is enhanced. Results of the activity observations will be provided to the Executive Director and trends noted will be reported to the facility PI committee.</p>	7/24/13
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F 248	Continued From page 5 The resident's care plan dated 3/25/13, included: provide resident with materials for independent leisure, invite resident to activities daily and escort her to and from activities. She likes to sweep, it appears to calm her. She likes jazz music, looking at magazines and 1 to 1 chatting. Multiple observations throughout the survey dates revealed the resident was walking up and down the hall or sitting in the living room, the television was on. RESIDENT 113 Resident 113 was admitted to the facility on [REDACTED]/13 with diagnosis to include [REDACTED] Multiple observations throughout the survey dates revealed the resident was watching television in the living room or laying in her bed. In an interview with Staff E, the Activities Director on 6/20/13 at 1:45 p.m., she stated, she understood there was a need for activities in the special care unit and she had hired a dedicated staff to start working there. The designated staff would be starting the following week, the new staff had specialized training and experience working with special care unit resident's.	F 248	Date Certain: July 24, 2013 Title of Person Responsible for Compliance: The Executive Director		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean,	F 252	F 252 Correction as it relates to the resident: Resident 50, 110, 147, 52, 122 and 153 rooms were decorated to feel more homelike. Room 114 and 316 had damaged walls repaired. Rooms 40, 203, 205, 207, 401 and Rainier Dining room had window blind slats replaced.	7/24/13	

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F 252	<p>Continued From page 6</p> <p>comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide a homelike environment for six residents (50, 52, 110, 122, 147, and 153) in the [REDACTED] unit. The failure to de-emphasize the institutional character in this setting had the potential to diminish the resident's quality of life. Additionally, resident rooms located in the main unit had damaged walls and or missing window blind slats.</p> <p>Findings include:</p> <p>Resident 50 resided in a three bed room. The walls were bare with the exception of a hand written sign "Do not send splints to laundry."</p> <p>Residents 110 and 147 resided in a room with two beds with night stands. The room was stark and barren of personal items.</p> <p>Residents 52, 122, and 153 resided in a three bed room. The room was stark and barren of personal items.</p> <p>When interviewed on 6/21/13 at 10 45 a.m., Staff E, in activities, stated family members and residents were encouraged to bring items from home and decorate. When asked if there was no family involvement, Staff E stated the Activity Department would provide items to help make the room more homelike. When asked about the</p>	F 252	<p>Action taken to protect residents in similar situations:</p> <p>Room rounds were completed to identify and correct barren resident rooms, damaged walls or broken/missing blind slats.</p> <p>Measures taken or systems altered to ensure the problem does not recur:</p> <p>Activity staff was educated by the Regional Nurse/designee regarding creating a homelike environment for our residents.</p> <p>Staff has been re-educated by the Staff Development Coordinator on identifying and reporting maintenance concerns via use of the communication book.</p> <p>Managers will complete room rounds weekly for three months to verify that rooms are decorated and maintenance issues are being identified and reported through use of the maintenance communication book. Findings of noncompliance will be forwarded to the Executive Director for immediate follow up.</p> <p>Plans to monitor performance to ensure solution is sustained:</p> <p>Results of the audits and maintenance request forms will be forwarded to the facility Performance Improvement Committee for three months</p>	7/24/13

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F 252	Continued From page 7 rooms in the dementia unit, the activity staff member stated it was on the resident's care plan to have the rooms appear as they did. A record review of the residents residing in these rooms failed to find any documented evidence in the care plans that they would prefer to have stark, barren rooms. Additional observations on 6/20/13 at 830 a.m. revealed damaged walls in rooms 114 and 316 by the resident's windows. Rooms 40, 203, 205, 207, and 401 had missing and or damaged window blind slats. The Rainier Dining Room had missing blind slats at the large window. Staff H, the Maintenance Director, was interviewed on 6/21/13 at 8:50 a.m. He stated it was the policy for employees to record any concerns for broken or damaged items in resident's rooms in a communication book. He indicated the book was reviewed several times a day. Upon inspection by the surveyor, nothing was recorded regarding the window blinds and damaged walls.	F 252	Date Certain: July 24, 2013 Title of Person Responsible for Compliance: The Executive Director	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care	F 279	F 279 Correction as it relates to the resident: Resident 6 care plan was updated to reflect current smoking and mobility status Action taken to protect residents in similar situations: Care plans for residents that smoke or have decreased mobility were reviewed and updated as required.	7/24/13

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F 279	<p>Continued From page 8</p> <p>plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to communicate and accurately date comprehensive care plans and assessments for Resident 6. Failure to communicate updated care plans that accurately reflected assessed care needs related to mobility and smoking placed the resident at risk of harm.</p> <p>Findings include:</p> <p>Resident 6 readmitted to the facility in [REDACTED], 2013 for rehabilitation and to increase ambulation abilities.</p> <p>On 6/17/13 at 8:45 a.m., the resident was observed to be smoking on the facility property. The resident was alone and was not wearing any protective gear. A review of a care plan dated April 2013 indicated the resident was to smoke</p>	F 279	<p>Measures taken or systems altered to ensure the problem does not recur:</p> <p>The interdisciplinary team was re-educated by the Staff Development Coordinator/designee regarding care planning completion requirements including individualization according to resident assessments. Care plans will be updated by members of the interdisciplinary team as changes occur and with quarterly and annual assessments.</p> <p>Plans to monitor performance to ensure solution is sustained:</p> <p>The MDS nurse will complete audits of the care plan based on the MDS assessment calendar to verify completion and individualization for no less than three months. Results will be forwarded to the Director of Nursing for further review and follow up as needed.</p> <p>The Director of Nursing/designee will present findings of the audit to the Performance Improvement Committee for 3 months to analyze performance improvement areas and to ensure system compliance.</p> <p>Date Certain:</p> <p>July 24, 2013</p> <p>Title of Person Responsible for Compliance:</p> <p>Director of Nursing</p>	7/24/13	

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F 279	Continued From page 9 only with supervision and to have a protective apron on per the facility policy. Because of the immediate safety concern, the Director of Nursing Services (DNS) and the Administrator were advised of the observation. The DNS was interviewed that same day at 10:45 a.m. She stated an assessment had been completed on 6/14/13 and the resident had been cleared by a nurse to safely smoke independently. A review of the resident's chart failed to provide any update since April of 2013. Another 4 care plans with various dates were found in the chart. They informed the reader the resident was either non-smoking as she was on a nicotine patch, smoked with supervision, or had her own smoking schedule. At 11:30 a.m. on 6/17/13, the nurse who completed the assessment on the 14th was interviewed. She stated she had completed a new assessment and placed it in the resident's chart. When reviewed with the nurse, she stated she incorrectly dated an assessment for 4/14/13 and it should have been for 6/14/13. When asked, the nurse stated she should have updated the care plan at that time and communicated with staff.	F 279			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309	F 309 Correction as it relates to the resident: Resident 148 pain was re-assessed and care plan updated. The MD was notified and dilaudid was changed from as needed to routine. Resident 148 continues to refuse pain consult even with facility offering to pay as resident's insurance does not cover that service. The physician was notified of resident's refusal of lidoderm patch and medication was discontinued. A care conference was held with resident to discuss his current pain management regime, resident verbalized that his pain is controlled.	7/24/13	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505272	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/24/2013
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MOUNT VERNON			STREET ADDRESS, CITY, STATE, ZIP CODE 2120 EAST DIVISION STREET MOUNT VERNON, WA 98273	
(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 309	<p>Continued From page 10</p> <p>mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provided pain management; including the treatment, monitoring, and management of pain to the extent possible in accordance with the comprehensive assessment and plan of care; for 1 of 5 resident's (148). This failure placed the resident at risk of diminished quality of life and unmet care needs.</p> <p>Findings include:</p> <p>Resident 148 was admitted to the facility [REDACTED] 2013 with a diagnosis of an [REDACTED], and [REDACTED].</p> <p>In an interview on 6/18/13 at 10:19 a.m., the resident stated "I have pain all the time with no relief." During the interview, the resident was repositioning himself frequently in bed, restless, with facial grimacing while stating "my back hurts."</p> <p>On 5/2/13, the primary physician was notified regarding the resident's pain. The nurse's progress note stated, the physician was faxed "to try to get better coverage with some long acting pain ..." medication. The resident was requesting the maximum dose of [REDACTED] (a [REDACTED]) every 3 hours for pain.</p>	F 309	<p>Action taken to protect residents in similar situations:</p> <p>Residents receiving frequent PRN (as needed) pain medication were assessed to identify the need for scheduled pain medication.</p> <p>Medication Administration Records (MAR) were reviewed for medication refusals, physicians notified and care plans updated per standard of practice.</p> <p>Orders were reviewed for consult requests to verify follow and no other issues were discovered.</p> <p>Measures taken or systems altered to ensure the problem does not recur:</p> <p>The Staff Development Coordinator provided training with the licensed nurses on pain management, assessing residents with frequent prn pain medication, notification of the physician for changing to routine and medication refusal process. The Resident Care Managers were educated on pain assessment and care planning.</p>	7/24/13

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F 309	<p>Continued From page 11</p> <p>Six days later, the physician responded to start [REDACTED] (a long acting [REDACTED]) in addition to the [REDACTED] as needed (prn). The pain flow sheet indicated the resident's pain level was 5-8 out of 10 using a numeric pain scale from 5/2/13 to 5/8/13. 0 indicated the resident had no pain, 5 was moderate pain, and 10 indicated severe pain.</p> <p>A week later, the primary care physician was notified regarding the resident's current pain medication was not working. At that time the physician ordered [REDACTED], a new pain [REDACTED], and discontinued the [REDACTED] and the [REDACTED]. The new order for [REDACTED] was to give 1 to 2 tablets every 3 to 4 hours prn for "severe pain."</p> <p>On 6/6/13, the facility notified the physician of the "resident taking [REDACTED] 4 mg" every 3 hours prn for pain. The facility requested a "pain consult" or to "try routine pain management." The physician ordered a pain consult on 6/7/13. The referral to the pain clinic was faxed on 6/17/13, ten days after the order was received.</p> <p>In an interview on 6/19/13 at 2:08 p.m., Staff A, a License Nurse (LN), stated the pain clinic required the physician to sign their consent form prior to the appointment being scheduled. When asked why this information was not faxed to the physician, Staff A replied the facility was waiting for the physician to come to the facility to lessen the possibility of the form being lost.</p> <p>The facility performed pain assessments on 5/7/13, 5/20/13 and 6/6/13. The resident stated his pain interfered with his mood, ability to ambulate, toileting and eating. The resident lost</p>	F 309	<p>Plans to monitor performance to ensure solution is sustained:</p> <p>MARs will be audited by Resident Care Managers/designee daily for two weeks then three times/week for two weeks then weekly for two months for medication refusal documentation, frequent PRN pain mend use follow up. Issues with documentation will be immediately addressed.</p> <p>Physician orders will be reviewed by the DON/designee daily M-F for completion. Needed follow up will be completed as indicated.</p> <p>Results of the audits will be provided to DON to present findings to the facility PI committee for three months to analyze performance improvement areas and to ensure system compliance.</p> <p>Date Certain:</p> <p>July 24, 2013</p> <p>Title of Person Responsible for Compliance:</p> <p>The Director of Nursing</p>	7/24/13
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F 309	<p>Continued From page 12 16 pounds from 5/1/13-5/28/13.</p> <p>The resident's care plan dated 5/16/13 was reviewed. The goal was the resident will express pain relief with current pharmaceutical and non pharmaceutical approaches including: "positioning, adaptive devices, warm/cold, therapies etc ..." However, no non-pharmalogical approaches besides re-positioning were performed by licensed staff per the pain flow sheet. In addition, the LN was to notify the physician if the resident did not state or demonstrate relief or reduction of pain after one hour of receiving the pain medication. The physician was not notified consistently of the residents ongoing pain and need for pain medication.</p> <p>From 6/1/13-6/18/13, the resident received the maximum dose of [REDACTED] 6-9 times a day prn for pain. The resident's pain averaged "6." The resident was consistently in moderate pain after three hours of the pain medication being administered. The resident continued to receive the maximum dose of [REDACTED] for his pain.</p> <p>On 6/19/13, a review of the June Medication Administration Record's (MAR) was done. The resident did not receive the [REDACTED] (a [REDACTED] medication) [REDACTED] daily as ordered. There was no nursing documentation of why the medication was not administered 11 out of 19 days.</p> <p>On 6/20/13 at 9:45 a.m., the Director of Nursing Services (DNS) was asked about the facility's policy regarding notifying the physician and documentation when a resident does not receive</p>	F 309	

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F 309	Continued From page 13 a medication. The DNS replied the standard of practice was to circle the MAR and write on the back the rationale why the medication was not given. The DNS confirmed this was not done regarding the resident's [REDACTED] On 6/21/13 at 1:00 p.m., a follow-up interview was conducted with the resident regarding his pain. The resident stated his pain was "6 most of the time." His goal was for his pain to be at a level "3." When asked about the pain clinic the resident replied, Staff A had just talked to him about it. The resident stated he was interested and he would "try anything once." The facility provided documentation that the resident refused the [REDACTED] and had refused the pain consultation. There was no evidence the facility did a comprehensive assessment of the data gathered by staff to determine the effectiveness of interventions of the medications and the effect of the resident's pain on his activities of daily living.	F 309			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F 323 Correction as it relates to the resident: NAC received corrective action for not following care plan for resident 29. Action taken to protect residents in similar situations: Residents at high risk for fall were reviewed for fall prevention measures and care plans were updated as indicated.		7/24/13

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F 323	<p>Continued From page 14</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide sufficient supervision to prevent accidents and/or ensure the resident's plan of care was appropriately implemented for 1 of 3 sampled residents (29). Failure to follow the resident's care directive or provide necessary staff supervision resulted in a resident fall with no injury.</p> <p>Findings include:</p> <p>The resident was admitted to the facility on [REDACTED] 12, with diagnosis to include [REDACTED]. The resident was considered a high fall risk secondary to poor impulse control. The resident had a history of falls.</p> <p>The resident's care directives dated 4/8/13, documented the resident required the assistance of 1 person for transfers.</p> <p>Review of an incident report dated 5/3/13, revealed a Nursing Assistant (NA) was assisting the resident to get ready for breakfast. The resident was standing up and the NA stepped outside of the room, to retrieve the residents wheelchair, leaving the resident alone. The resident lost her balance and fell, hitting her head on the wall.</p> <p>In an interview with the NAC on 5/3/13, she stated, "I should have sat the resident down before leaving to get the chair."</p> <p>In an interview with the DNS on 6/21/13 at 2:00</p>	F 323	<p>Measures taken or systems altered to ensure the problem does not recur:</p> <p>Nursing assistants were educated on following the care plan fall prevention measures.</p> <p>Plans to monitor performance to ensure solution is sustained:</p> <p>Rounds will be completed by the Resident Care Managers/ designee weekly for 4 weeks then monthly for 3 months to ensure care plans are followed. Any identified issues will be corrected. The results of the rounds and audits will be reviewed by the Director of Nursing and brought to the PI committee monthly for three months to identify trends or further educational needs and to ensure ongoing compliance.</p> <p>Date Certain:</p> <p>July 24, 2013</p> <p>Title of Person Responsible for Compliance:</p> <p>Director of Nursing</p> <p style="text-align: right;">7/24/13</p>

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F 329	<p>Continued From page 16</p> <p>by: Based on record review and interview, the facility failed to ensure monitoring of the usage and response to non-pharmacological interventions for 1 of 10 (96) sample residents reviewed for unnecessary medications. This failure placed residents at risk for receiving psychoactive medications that may not have been needed.</p> <p>Findings include:</p> <p>A review of the facility's policy for "Psychotropic Medication Administration Mental Health Referral Consultation" with a reviewed date of 10/08 directed facility staff to:</p> <ul style="list-style-type: none"> - complete a behavior monitor record by the nurse administrating the medication. - "Upon receipt of "new" order for a psychotropic medication. . . documentation in the nurses' notes the specific behavior/diagnosis for the medication. . ." <p>Resident 96 was admitted [REDACTED] 2013 with diagnosis to include [REDACTED], [REDACTED], and [REDACTED]</p> <p>A review of the physician orders was conducted. The resident was admitted with medications to include [REDACTED] (an [REDACTED] medication) as needed (PRN) daily for [REDACTED] and [REDACTED], and [REDACTED] (an [REDACTED] medication) daily for [REDACTED] with [REDACTED].</p> <p>On 6/19/13, a review of the Medication Administration Record (MAR) and behavior monitoring flow sheets for May and June 2013 was completed. The nursing staff was to monitor</p>	F 329	<p>Measures taken or systems altered to ensure the problem does not recur:</p> <p>The Licensed Nurses (LN) and the behavior management interdisciplinary team were educated by the Staff Development Coordinator on the psychotropic medication policy including utilizing non-pharmacological interventions prior to medication administration, documentation of those attempts utilizing the behavior monitoring flow sheet and carrying out physician orders as written or seeking clarification when needed.</p> <p>The behavior management team will continue weekly psychotropic management meetings to review residents on psychotropic medications to ensure compliance with facility policy.</p> <p>Plans to monitor performance to ensure solution is sustained:</p> <p>Minutes from the weekly behavior management meetings will be forwarded to the DON for immediate follow-up as needed. The DON will present audits of the behavior management meeting minutes to the facility Performance Improvement committee for three months to ensure comprehension and compliance with facility policy.</p> <p>Date Certain:</p> <p>July 24, 2013</p> <p>Title of Person Responsible for Compliance:</p> <p>The Director of Nursing</p>	7/24/13
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F 329	<p>Continued From page 17</p> <p>each shift for episodes of [REDACTED] and "exit seeking to go home." [REDACTED] was defined as "SOB" (shortness of breath). The nursing staff was directed to attempt a variety of non-pharmalogical interventions to the resident prior to giving a prn medication. Example of these interventions included to: redirect, give food, toilet, return to room and change position. There was no evidence of consistent attempts at non-pharmalogical interventions for behaviors prior to the use of [REDACTED]</p> <p>There were no June behavior monitor flow sheets. Furthermore, the MAR revealed [REDACTED] was given three times on 6/1/13 without a doctor's order.</p> <p>On 6/20/13 at 1:00 p.m., Staff B, a License Nurse (LN), was interviewed regarding the use of the behavioral flow sheets. Staff B stated, the LN was responsible to fill out the behavior monitor every shift. Prior to administrating a PRN psychotropic medication, the LN was to attempt non-pharmalogical interventions and determine what caused the behavior.</p> <p>On 6/20/13 at 9:40 a.m., the Director of Nursing Services (DNS) was interviewed regarding the resident's mediation regimen and the missing behavioral monitoring sheets. The facility was not aware of the resident received unscheduled [REDACTED] on June 1 until brought to their attention by the surveyor. The DNS confirmed the resident's June behavioral monitoring sheets were missing.</p>	F 329		7/24/13
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F 441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</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> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p>F 441</p> <p>Correction as it relates to the resident:</p> <p>No residents were named in this citation.</p> <p>Action taken to protect residents in similar situations:</p> <p>The hand sinks in the kitchen have been inspected and parts have been ordered and will be fixed when available to the facility.</p> <p>A dirty linen bin has been provided to Laurel Haven dining room.</p> <p>Measures taken or systems altered to ensure the problem does not recur:</p> <p>The Kitchen Staff have been educated to utilize warm water to wash their hands per facility policy. They will report water temperature concerns to maintenance.</p> <p>Staff that assist in the dining room have been re-educated to wash hands after touching dirty items prior to touching clean items and to utilize dirty linen bin.</p>	7/24/13
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F 441	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow it's policy for hand washing. Kitchen staff failed to use warm water to wash their hands. In the dementia unit, a staff member was observed to handle soiled clothing protectors and not washing their hands. These failures had the potential to introduce diseases to the residents of the facility. Findings include: KITCHEN Multiple observations on 6/21/13 from 11:00 a.m. to 11:30 a.m., revealed kitchen staff using two hand washing sinks. A surveyor used one sink at 11:30 a.m. and noted the water failed to reach a warm temperature. Temperatures were taken of the water coming out of the hot water facet of the two hand washing sinks. After running water for 3 minutes, the temperature ranged from 55 to 60 degrees Fahrenheit. Observations at 1:33 p.m. revealed three kitchen staff washing their hands. When the water temperature was checked again by the surveyor, it registered 55 degrees at both sinks. At 11:40 a.m., Staff F, the Dietary Manager was interviewed. When asked about the lack of hot water in the sinks, she stated: "You have to turn the hot water on in the three compartment sink (across the kitchen, along a wall)." "After three to five minutes, the hot water will start to circulate into at least one sink." When asked by the surveyor if this was feasible and if staff waited that long, she stated: "Probably not."	F 441	Plans to monitor performance to ensure solution is sustained: The hand sink water temperature will be checked daily for one week then three times/week for three weeks then weekly for two months, maintenance will be notified when water is not warm when checked. Trends of the temperatures will be presented to the facility PI committee. Dining room observations will be completed by the Staff Development Coordinator / Designee weekly for three months, immediate follow up will be completed if any concerns are noted. Results of the dining room observations will be provided to the Executive Director any trends noted will be reported to the facility PI committee. Date Certain: July 24, 2013 Title of Person Responsible for Compliance: The Executive Director	7/24/13	

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F 441	Continued From page 20 A review of the facility hand washing policy indicated warm water was to be used. When the Administrator was interviewed on the same day at 3:00 p.m., she indicated the water should be warmer. LAUREL HAVEN DINING ROOM During observations on 6/17/13 at 12:30 p.m., Staff G, a nursing assistant was observed to pick up dirty clothing protectors. After gathering them and putting them in the "dirty" pile, she proceeded to leave the dining room without washing her hands. She returned to the dining area, holding clean washcloths. She then proceeded to assist residents to clean up with the washcloths. No hand washing was observed in between handling of the dirty clothing protectors and the clean washcloths.	F 441			
F 514 SS=D	483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any	F 514	F 514 Correction as it relates to the resident: Resident 96 had a behavior flow sheet initiated. Resident 148 will have behaviors flow sheets completed Action taken to protect residents in similar situations: Residents receiving psychotropic medications, telephone orders and assessments completed have a potential to be affected by this practice and will have accurate documentation to reflect care and services provided and resident medical records will be complete, accurate and in accordance with accepted professional standards	7/24/13	

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F 514	<p>Continued From page 21 preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure accurate, complete and organized clinical information for 3 of 21 residents (96, 148, and 6) reviewed for documentation accuracy. This failure placed the residents at risk for not having their medical records complete and/or accurate and made it difficult to determine resident response to medications and interventions.</p> <p>Findings include:</p> <p>The facility's policy for "Psychotropic Medication Administration Mental Health Referral Consultation" dated 10/08 was to monitor behaviors regarding the use of psychotropic medications which included anti-anxiety and anti-psychotic medications.</p> <p>RESIDENT 96 Resident 96 was admitted to the facility [REDACTED] 2013.</p> <p>A record review of the physician orders revealed the resident received: [REDACTED] (an [REDACTED] medication) as needed daily and [REDACTED] (an [REDACTED] medication) daily.</p> <p>On 6/19/13 the resident's Medication Administration Records (MAR) were reviewed. There were no behavior monitoring sheets for the month of June.</p>	F 514	<p>Measures taken or systems altered to ensure the problem does not recur:</p> <p>The Licensed Nurses were in-serviced on thorough and accurate documentation including behavior monitoring, assessment and care plan completion dates.</p> <p>The behavior monitoring flow sheets will be audited by the Nurse Managers weekly for 3 months to ensure they are completed as required.</p> <p>Telephone orders will be reviewed M-F by Director of Nursing/designee to verify date is accurate.</p> <p>Care plans and assessments will be reviewed by the MDS coordinator according to the MDS calendar to verify completion dates are accurate/appropriate.</p>	7/24/13	

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505272	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/24/2013
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F 514	<p>Continued From page 22</p> <p>On 6/20/13 at 9:40 a.m., the Director of Nursing Services (DNS) confirmed there were no June behavior monitoring sheets.</p> <p>RESIDENT 148 Resident 148 was admitted [REDACTED] 2013.</p> <p>A record review of the physician orders identified the resident's orders to include [REDACTED] (an [REDACTED] medication) as needed, and Remeron (an [REDACTED] medication) daily.</p> <p>On 9/20/13 at 9:30 a.m., the resident's June MAR's were reviewed. The resident behavior was monitored every shift. There was missing documentation for episodes of paranoia 48 out of 57 times and for verbal abuse towards staff 50 out of 57 times.</p> <p>On 6/20/13 at 9:45 a.m., the DNS confirmed the lack of documentation on the behavior monitor sheets.</p> <p>RESIDENT 6 Resident 6 readmitted to the facility in [REDACTED], 2013 for rehabilitation and to increase ambulation abilities. A review of the resident's record on 6/17/13 at 9:10 a.m. revealed multiple errors with dates of assessments and care plans. Additionally, a telephone order dated 8/14/13 was discovered in the same resident's record on 6/17/13, two months into the future.</p> <p>During an interview with the DNS on 6/17/13 at 10:45 a.m., she indicated the care plans were confusing and a nurse had included the wrong date on an assessment and telephone order.</p>	F 514	<p>Plans to monitor performance to ensure solution is sustained:</p> <p>The results of the audits will be reviewed by the Director of Nursing and presented to the PI Committee monthly for 3 months to ensure that the changes implemented are effective and appropriate.</p> <p>Date Certain:</p> <p>July 24, 2013</p> <p>Title of Person Responsible for Compliance:</p> <p>The Director of Nursing</p>	7/24/13
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7/24/13

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