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

1394

PRINTED: 06/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	505017		02/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CENTER FOR COMPREHE	2821 SOUTH WALDEN STREET SEATTLE, WA 98144

(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	INITIAL COMMENTS	F 000		

This report is the result of an unannounced Quality Indicator Survey conducted at Wahington Center For Comprehensive Rehabilitation on 02/07/13, 02/08/13, 02/11/13, 02/12/13, 02/13/13 and 02/14/13. A sample of 34 residents was selected from a census of 154. The sample included 28 current residents, the records of six former and/or discharged residents and three supplemental residents.

The survey was conducted by:

[redacted], RN, MN
[redacted], MSW
[redacted], RN, MN
[redacted], RN, BSN
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The survey team is from:

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Residential Care Services Date 6/14/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	6-21-13

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 156	483.10(b)(5)-(10}, 483.10(b)(1) NOTICE OF SS:::D' RIGHTS, RULES, SERVICES, CHARGES	F 156		

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.

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 tile 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.

The facility informs 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 the nursing facility services under the State Plan and for which the resident may not be charged, 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.

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.

The facility informs each resident before, or at the time of admission, and periodically during the resident's

The facility must furnish a written description of legal rights which includes:

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F 156	Continued From page 2 A description of the manner of protecting personal funds, under paragraph (c) of this section; 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. 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. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. 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 Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by		F 156; stay, of services available in the facility and of charges for those services, including any charges for those services not covered under Medicare or by the facility's per diem rate. There is documentation in Resident # 137, 144, and 246 medical record and in business office file indicating that they were informed of their rights, benefits and services for which they may be charged and the amount of these charges. The facility utilized documents and Form 1005 SNFABN, that was outdated but will implement policies and procedures utilizing these updated Form and processes. To our knowledge there were no oversights related to notification of legal rights related to posting of Medicare/Medicaid eligibility, pertinent State advocacy agencies and contacts, or procedures regarding advance directives, rights to refuse treatment(s) Compliance monitored by B.O. Administrator to ensure compliance	3-27-13 and ongoing

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F 156	Continued From page 3 such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide required liability notices for three (#s 137, 144 & 246) of three residents reviewed for liability notices. Failure to do so placed the residents at risk for not being fully informed of and/or L!nderstanding their Medicare benefits. Findings include: RESIDENT #137 Record review revealed Resident #137 received Medicare part A services. The services ended on 11/19/12. In an interview on 02/14/13 at 11:36 a.m., Staff F said the resident remained in the facility with a private payor source after the Medicare services ended. The Notice of Medicare Non-Coverage, dated 11/15/12, was signed by the resident's representative. The facility failed to provide an additionally required form to ensure the resident had the option to continue services that would not be covered by Medicare (CMS form 10055 SNF ABN). In an interview on 02/14/13 at 12:55 p.m. Staff G said form 10055 was not provided to residents when their Medicare services ended. She explained the facility provided a blank, older version of the form (form NEMB-SNF) in each admission packet for residents who admitted.on Medicare part A services. She acknowledged that form was not completed by the facility or signed by the resident or their representative at the time a resident was discontinued from Medicare services.	F 156		

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Similar findings were identified for Resident #144 whose Medicare part A services ended on 09/17/12. The resident remained in the facility with Medicaid as a payor source after Medicare services ended. There was no indication form 10055 SNF ABN was provided.

RESIDENT #246
Record review revealed Resident #246 received Medicare part A services that ended on 11/11/12. The Notice of Medicare Non-Coverage revealed the resident's Power of Attorney (POA) was notified by telephone on 11/09/12 and that a copy of the notice would be mailed. In an interview on 02/14/13 at 10:00 a.m., Staff M stated she left a message for the POA on 11/09/12 requesting an address, however she did not receive a call back. She stated she did not attempt additional contact to obtain an address to which the notice could be mailed. There was no evidence the written notice was mailed or otherwise delivered to the resident's POA. In addition, the facility did not provide the additional notice, form 10055 SNF ABN.

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F 241 SS=D 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

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.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility

F 241
The facility promotes care for residents in a manner and in an environment that maintains and enhances each resident's dignity and respect in full recognition of his or her individuality.

The Dining Room events as described did not coincide with our same experience and observations. Additionally it is difficult to follow-up these statements due to no identification for resident # 236 who appears to have had a major role in these events.

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F 241

failed to promote care for all residents in a dignified manner. Failure to provide a dignified dining experience for all residents, the observed practice of pulling residents backwards in their wheelchairs, and women with unremoved facial hair placed residents at risk to not feel valued and respected and contributad to decreased quality of life.

Findings include:

DINING OBSERVATIONS

On 02/07/13 at 12:10 p.m. in the 2 East dining room, Resident #207 was observed to propel his wheelchair backwards. Resident #236, one of three residents seated at a table behind Resident #207, said, "Here he comes, here he comes". Resident #236 stood up and physically turned Resident #207's wheelchair around so he would not hit the table. As Resident #236 sat back down she stated, "He doesn't have sense to put his head up." Resident #207 again propelled his wheelchair backwards. Resident #236 said to Resident #207, "Where do you think you're going? You're not going anywhere, you're going against the wall." Resident #236 again grabbed Resident #207's wheelchair and asked Staff FF, who had been nearby throughout the interaction, "Can you help?!" Staff FF then intervened and assisted Resident #207 back to his table. Failure by staff to intervene and manage resident's interactions in a timely manner caused Resident #207 to be spoken to in a disrespectful manner and placed other residents at risk to feel ignored.

On 02/07/13 at 12:27 p.m. in the 2 East dining room, staff discarded the tray cards before serving beverages. One staff member was

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F 241	Continued From page 6 overheard to call out regarding a resident, "She's regular" to another staff member getting milk. Using labels to describe residents placed them at risk to feel devalued. On 02/07/13 at 12:59 p.m. in the 2 East dining room Resident #236 was observed to stand up and fuss with a table. Staff EE was heard to state to Resident #236, "Don't do that! Go to your room!" On 02/12/13 at 12:46 p.m. in the 2 West dining room, Staff R, while attempting to push the room tray cart through the dining room, said to Resident #224, who was eating, "Can I move you? I can't make it through." After the cart was through the area, Staff R moved Resident #224 back to the same table, but on a different side, not in front of her lunch plate. As Staff R left the room, Resident #224 called out, "Don't come back this way!" TRANSPORTING RESIDENTS On 02/07/13 at 12:01 p.m., Staff X, CNA, was observed to pull an unidentified resident backwards down the hallway in a shower chair. The resident was covered with a white blanket. On 02/09/13 at 1:25 p.m., Resident #293 was observed to ask for help to use the bathroom. Staff Z was observed to pull the resident's wheelchair backwards from the nurse's station to the resident's room, approximately 25 feet. Pulling residents backwards in their wheelchairs placed them at risk to feel not valued or cared for. WOMEN'S FACIAL HAIR	F 241	Staff R. recalls being complimented for her interactions resident #224. The resident, when interviewed, expressed positive interactions with staff. Staff are in-serviced regarding dining room service and appropriate interactions. A Licensed Nurse and/or a manager are present in all dining rooms during meals to supervise. Resident # 293 has a room that is located directly across from the nursing station. Backing residents over thresholds of bathrooms and elevators is considered appropriate even providing less risk to the patient's lower extremities. We are unable to follow up on an unidentified resident but will inservice staff regarding acceptable transport practices.	

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RESIDENT #287

Observation throughout the survey from 02/07/13 through 02/14/13 revealed resident #287 had multiple chin hai;s, one of which was approximately an inch long.

In an interview on 02/12/13 at 10:30 a.m. the resident referred to her chin hairs and stated, "they are really horrible (chin hairs), I think it's the male hormone coming out in me." The resident indicated at that time she would like her facial hairs removed.

In an interview on 02/14/13 at 10:37 a.m., Staff S (a Nursing Assistant-NA), indicated, "The NAs are the ones who give showers." Staff S indicated that facial hair and nail care was addressed during bathing. She was unable to explain why this had not been addressed for Resident #287.

Similar findings were identified for Resident #214, who was unable to express her preferences, but was observed on 02/08/13 at 12:36 p.m. with facial hair (over an inch long) on the left side of her chin. Resident #288 was observed on 02/08/13 at 8:59 a.m. with multiple facial hairs approximately 1/8th inch long on both sides of her chin. Resident #293 was also observed with unattended facial hair. Resident #108 was observed on 02/08/13 at 2:24 p.m. with numerous curly chin hairs. Unremoved facial hair placed these female residents at risk for feelings of low self-esteem.

F 247 SS=E 483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE

A resident has the right to receive notice before

F 241

Resident's receive daily assist with grooming, hygiene, and facial hair is removed as is their preference. Resident # 287 preferred the beautician to do so. Staff S is not a "she" but indicated that he would remove chin hairs upon request. Resident # 108 indicated, she would inform staff if she needed assist with removal of chin hairs. Staff will continue to re-approach.

Bathing/Grooming in-service will be conducted on all units. Unit Managers oversee the daily care.
All staff are responsible for ensuring the residents are treated in a dignified manner.

DNS will ensure compliance with Dignity of Resident Care

3-7-13 and ongoing

A Resident does receive notice before the resident's room or roommate in the facility is in process of change.

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the resident's room or roommate in the facility is changed.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, it was determined the facility failed to notify three of three residents (#s 201, 14 & 268) reviewed for roommate changes. This failure denied residents their right to be informed and involved in the process of roommate changes.

Findings include:
According to the undated Admission Agreement, "The facility will notify Resident as soon as practicable prior to a change in room or roommate." According to the undated Internal Transfers Procedure, "Social Services or Nurse Manager will... initiate discussions of internal transfers... and informing new roommate. Documentation regarding internal transfers will be completed in the medical record... Receiving Nurse will receive report and place resident on Alert Charting for 3 days to monitor for adjustment."
RESIDENT #201
In an interview on 02/11/13 at 9:36 a.m., Resident #201 said she had a roommate change three weeks prior and was not given notice. She stated the facility "just moved in roommate."RESIDENT #14
In an interview on 02/08/13 at 2:10 p.m. Resident #14 said she had a change in roommate and commented "they don't ever tell me, 'You're

F 247

Residents # 201, 268 and 14 are on a Post-Acute Care floor with frequent admissions and discharges. Resident # 14 is in a Private Space. The Admission Nurse introduces new residents to room. If these are transfers SW will inform roommates as soon as possible that they will have a new roommate and document this discussion. SW and Admission Nurse will be responsible for compliance and documentation.
Administrator will ensure compliance.

2-14-13
and
ongoing

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F 247	Continued From page 9 getting a new roommate'." RESIDENT #268 In an interview on 02/11/13 at 9:14 a.m., Resident #268 said he had two roommates both of whom had since discharged. Resident #268 said "nobody told me ahead of time I was getting a new person in my room." Review of Resident #268's record revealed no written notice of roommate changes, nor alert charting monitoring the resident's adjustment to the new roommate. In an interview on 02/14/13 at 11:00 a.m. Staff F said either the Nurse or Social Services "needs to inform the roommate that a new roommate is coming." Staff F said "we don't have a form for that, it's more of a process", an "informal process of verbally telling them." In addition, Staff F indicated the facility did not initiate Alert Charting for the recipient of the new roommate. Staff F was unable to provide further information that indicated the above three resident's were informed prior to a roommate change.	F 247		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 279:	Facility uses the results of the assessments to develop, review and revise the resident's comprehensive plan of care. The facility develops a comprehensive care plan for each resident that includes measureable objectives and timetables to meet a resident's medical, nursing, mental and psychological needs that are identified in the comprehensive assessment.	2-14-13 and ongoing

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F 279	Continued From page 10 assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop and/or revise comprehensive care plans for two of 16 sample residents (#s 170, 23). Failure to establish care plans with measurable goals that accurately reflected assessed care needs and provide direction to staff on the residents' care placed residents at risk to receive less than adequate care. Findings include: RESIDENT #170 The 2/13 Mood State care plan (CP) revealed Resident #170 was "non-compliant with fluid restrictions and low potassium diet". The identified goal was the resident would not "drink as much soda or eat as many potato chips." In an interview on 02/13/13 at 10:20 a.m., Staff T acknowledged the goal was not measurable, as staff did not know how much constituted "as much or as many." Staff T stated the goal should	F 279	Resident # 170's Care Plan was modified to remove this goal. It is not realistic to monitor his on-going non-compliance due to mobility, mental status and being frequently out of facility. RECEIVED JUN 25 2013 DSHS/ADSA/RCS	

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include an amount so staff could determine if the resident made progress towards the goal.

RESIDENT #23

In an interview on 02/07/13 at 2:17 p.m., Staff C stated the resident had impaired range of motion but did not receive a restorative program due to refusals.

The AOL CP identified the resident with the potential for decreased AOL function related to physical weakness / deconditioning; pain and a past [redacted] to her [redacted] and [redacted]. The goal was for the resident to have improved AOL function "along the pathway of rehabilitation". Identified interventions were, "Locomotion Total (assistance)" and "Refuses restorative program and ambulation to dining room. States it causes knee pain. Only uses w/c for mobility. RNP dc'd." There were no listed interventions that reflected how the resident would meet the goal of improved function.

In an interview on 02/13/13 at 10:05 a.m., Staff C stated the goal "should not be improving, it should have been changed when the restorative program was discontinued". She stated the goal should be for the resident to maintain her current functional status, as she would not participate in services designed to help her improve.

In addition, Resident #23 had a 04/20/12 physician's order for routine [redacted] for [redacted]. Review of her comprehensive care plan revealed no care plan that addressed insomnia. In an interview on 02/13/13 at 9:45 a.m., Staff C acknowledged a care plan for insomnia should be, but wasn't, in place.

F 279,

Resident # 23 did not have a Care Plan for "insomnia" because it was not triggered by the Comprehensive Assessment. There were monitors in place to determine if herbal supplement was effective. On 12/20/12 the Care Plan had been updated to reflect "ADL needs will be met in next 90 days". This was appropriate for this resident.

Care Plans are updated as appropriate with changes of condition and per MDS assessment process.

Unit Managers monitor compliance.
DNS insures compliance

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F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to follow plans of care for one (#170) of one residents reviewed for dialysis, one (#268) of three residents reviewed for accidents and one (#108) of three residents reviewed for Range of Motion. The facility failed to monitor fluid intake for a resident who was on a fluid restriction, follow fall precautions, announce themselves before entering a resident's room and implement a restorative program as planned. These failures placed residents at risk for falls and a decreased quality of life. Findings include: RESIDENT #170 Record review revealed Resident #170 received [redacted] due to [redacted]. The Risk of Dehydration CP identified while the resident was non compliant with fluid intake, nurses were to complete an intake monitor related to the fluid restriction. The care plan noted the "Fluid intake documentation is an estimate by (nurses) based on what they give him to drink and what comes on meal trays." Review of the January 2012 Medication	F 282,	.The services provided or arranged by the facility are provided by qualified persons in accordance with each resident's written plan of care. Resident's Electronic Medication Administration record was modified to include fluid intake of resident. Very challenging given resident's non-compliance and is frequently out of facility. Regarding Resident # 268 and #108, staff have been re-inserviced regarding following care guides, verbal report of changes and knocking on doors. (This had been identified by resident who regularly informs of issues.) Staff T is a Social Worker and was not questioned about RA program as stated, RA's are expected to follow Care Plans and individualized RA programs, documenting appropriately Unit Managers oversee Care and monitor for compliance. DNS to monitor to ensure compliance RECEIVED JUN 25 2013 DSHS/ADSA/RCS	

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Administration Record (MAR) revealed the resident had a "Fluid goal of 1 liter in 24" hours. Staff documented the resident's fluid intake each shift through 01/20/13.

In an interview on 02/13/13 at 10:10 a.m., Staff C stated the resident's MAR was moved to the facility's computer system in mid-January. She stated when that was done staff failed to add a place to document the amount of fluid the resident consumed. She stated staff made a check mark each shift instead of a fluid amount. She stated staff should have recorded the resident's fluid intake each shift, but had not done so since 01/20/13.

RESIDENT #268

Review of the 02/07/13 Minimum Data Set (MOS) assessed the resident required extensive one person assistance with bed mobility, and two person extensive assistance with transfers.

The 12/16/12 Fall care plan (CP) identified the resident was at risk for falls and potential injury related to physical [redacted], [redacted], [redacted], [redacted] [redacted] of safety and a [redacted] [redacted] and had a history of falls. This CP identified an intervention that directed staff to "keep bed in it's lowest position when res(ident) is in bed."

Review of incident reports revealed the resident sustained falls from his bed on 12/03/12 at 3:45 a.m., 12/03/12 at 4:26 n.m., 12/15/12 at 10:49 p.m. and 12/20/12 at 1:30 p.m.

In an interview on 02/13/13 at 10:54 a.m., Resident #265 recalled previous falls, one of

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F 282 Continued From page 14

which, "I was sitting on the side of the bed and I slid right down on the floor", and another "I guess I went to sleep and I guess I was on the floor." The resident was observed sitting on his bed. The bed was not in the lowest position at that time.

On 02/14/13 at 10:30 a.m., the resident was observed in bed. The bed was not in the lowest position. Resident #268. stated a staff member helped him to bed. At that time, Staff R stated she: assisted the resident to bed, as she always did after breakfast. She stated before she left the room she gave him the call light and placed his table near his bed. When asked if the bed was in the lowest position, she replied, "No, it's not" and then lowered it. She stated she was unaware the resident was on fall precautions.

RESIDENT #108
During an interview with Resident #108 in her room on 02/08/13 at 1:47 p.m., an unidentified nurse called the resident's name as she entered the room. When she noticed the resident was in the middle of an interview she stated, "Oh, excuse me", told the resident about an upcoming doctor's visit, and then left the room. Resident #108 stated she often sat with her back to the door and the privacy curtain half pulled and that staff frequently entered without knocking or waiting for a response. She stated there were many times she did not know staff were in the room until they walked in front of her, which sometimes frightened her.

On 02/11/13at12:41 p.m., a housekeeper was noted to enter the resident's room without knocking. She began to sweep the floor, then noticed the resident speaking to the surveyor and

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F 282	Continued From page 15 stated, "Oh, I'll be back". She then left the room. Review of the 12/11/12 Cognitive Loss/Dementia CP identified the resident was cognitively intact. An intervention directed staff to "Respect Res(ident) privacy, knock before entering, Res. treats her room as an apartment." Failure by staff to follow this care plan placed the resident at risk for a decreased quality of life. According to the 01/10/13 MDS, Resident #108 was assessed with functional [redacted] in [redacted] and [redacted] According to the 08/12/12 Limited Physical Mobility CP, interventions initiated 01/03/13 included "Application of splint to [redacted] Goal 2 hrs on then remove." Additional range of motion exercises were listed, none of which included the use of weights. In an interview on 02/11/13 at 12:34 p.m.. Resident #108 said the day prior the Restorative Aid (RA) "Came to get me and we did exercises with weight on ankle, lift up, two pound weight in my hand to stretch arm out, and [redacted] hand." Resident #108 was observed with what appeared to be a [redacted] A splint was observed on the resident's bed. When asked how long she wore the [redacted] Resident #108 said "She told me to wear it as long as I could in the day time and if it hurt to take it off." She stated she "started at two hours, now I usually keep it on until dinner which is like 5:30 p.m.." Review of documentation of the RA program for the past 30 days revealed staff did not document	F 282		

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F 282	Continued From page 16 ap.plication of the [redacted] or indicate for how long the [redacted] was applied. In an interview on 02/14/13at1:02 p.m. StaffT said the [redacted] on for two hours, "but sometimes she goes to activities with it on and we can't take it off, so sometimes longer." Sometimes, "she's had it on for four hours." Staff T said when performing Range of Motion "she uses a two pound weight for the arm she can do herself and we do a wrap of one pound weight on the other arm, and weights on her legs of, I think three pounds." Staff B provided the 12/27/12 Therapy RA Referral Form. Staff T reviewed it and concurred the RA program did not direct staff to utilize weights, nor was the program implemented as planned. In an interview on 02/14/13 at 12:24 p.m. Staff B indicated she expected the RA to perform the tasks as directed on the CP.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure two of three dependent residents reviewed for Activities of Daily Living received oral care (#108) or personal	F 312	A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal hygiene	2-14-13 and ongoing

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hygiene (#287) in addition to three (#s 214, 288 & 293) supplemental residents. Failure to ensure oral hygiene services were provided placed the resident at risk for further tooth decay, pain related to gum disease, poor hygiene and dissatisfaction with care. Failure to ensure removal of unwanted facial hair detracted from residents sense of well being.

Findings include:

RESIDENT #287
According to the 01/30/13 Minimum Data Set (MOS), Resident #287 was admitted to the facility with diagnoses including [redacted] and was assessed to require extensive one person physical assistance with personal hygiene.

Observation throughout the survey from 02/07/13 through 02/14/13 revealed the resident had multiple chin hairs, one of which was approximately an inch long.

In an interview on 2/08/13 at 10:20 a.m., the resident, referring to and stroking her chin hairs stated, "at (Assisted Living facility) I had a beautician who would pluck them for me.. they haven't done that (here)... I think they think I can do it (trim facial hair)...". In an interview on 02/12/13 at 10:30 a.m. the resident referred to her chin hairs and stated, "they are really horrible (chin hairs), I think it's the male hormone coming out in me." The resident indicated at that time she would like her facial hairs removed.

In an interview on 02/14/13 at 10:37 a.m., Staff S (a Nursing Assistant-NP.), indicated, "The NAs are the ones who give showers." Staff S indicated

F 312

Residents # 287, 288 and 293 (#214 was not identified on resident roster) have been approached regarding chin hairs, #287 requested service by beautician, #288 and #293 refused. Resident #108 had several toothbrushes, she keeps them in her drawer in her own personal basin, stored appropriately and easy to access.

Nursing staff are in-serviced regarding grooming and hygiene, a standard of practice. Removal of chin hairs is a personal preference which the staff respect.

Unit Managers monitor for compliance.
DNS ensures compliance

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that facial hair and nail care was addressed during bathing. Failure to ensure removal of female facial hair placed the resident at risk for dignity issues.

Similar findings were identified for Resident #214, who was unable to express her preferences, but was observed on 02/08/13 at 12:36 p.m. with facial hair (over an inch long) on the left side of her chin. Resident #288 was observed on 02/08/13 at 8:59 a.m. with multiple facial hairs approximately 1/8th inch long on both sides of her chin. Resident #293 was also observed with unattended facial hair. Resident #108 was observed on 02/08/13 at 2:24 p.m. with numerous curly chin hairs.

RESIDENT #108
According to the 01/10/13 MDS, Resident #108 was assessed to require one person extensive assistance with personal hygiene.

The 02/11/13 Dental Care impaired oral/dental status Care Plan listed the intervention to assist with oral care twice a day and as needed, set up and/or supervise.

In an interview on 02/08/13 at 2:14 p.m. Resident #108 stated, "I asked for a toothbrush the other day but they haven't brought me one yet." "I only have a few teeth, so I guess they don't think I need it." The resident was observed with yellowed, broken and missing teeth.

In an interview on 02/11/13 at 12:42 p.m. a toothbrush was found in the top drawer of the resident's bedside dresser. The toothbrush was not bagged, with dry, dirty bristles. Resident #108

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stated, "I asked him today for a toothbrush, he said they were busy, he had to go on his break so he probably forgot... he washed my face and then he had to leave." Staff V entered the room and Resident #108 was observed to ask him to bring her a toothbrush, toothpaste and mouthwash when he could. Staff V replied, "yes" he would.

In an interview on 02/14/13 at 9:31 a.m. Resident #108 said a female staff member brought her a toothbrush and toothpaste on 02/13/13 and she brushed her own teeth with set up.

F 312

F 329 SS=E 483.25(1) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

F 329

Each resident's drug regimen is free from unnecessary drugs, including drugs 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 reason above.

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed.to have a medication administration system which ensured each resident's drug regimen was free from unnecessary drugs for six of 10 residents reviewed for unnecessary medication use. The facility failed to implement non-drug interventions prior to the administration of as needed medications for Resident (#s 17, 279 & 126). The facility failed to ensure Resident (#s 279, 23 & 42) received adequate monitoring and/or had indications for use to ensure continued need of medications. The facility failed to conduct gradual dose reductions for Resident #11. These failures placed residents at risk for the use of unnecessary medications and harm from side effects.

Findings include:

FACILITY POLICY
According to the facility's policy on psychoactive drug treatment, "Resident will receive only those medications in doses and for a duration clinically indicated to treat their condition...". This policy directed staff that, "Non-pharmacological interventions will be considered and used when indicated, instead of, or in addition to, psychoactive medication."

RESIDENT #17
According to the 01/10/13 Minimum Data Set

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F 329	Continued From page 21 (MOS), Resident #17 had diagnoses including [redacted] and [redacted]. Review of Care Plan (CP) documents dated 01/13/13 revealed the resident had a decline in mood state. Interventions included: "res(ident) finds using her electronic cigarettes to be something that sooths her. Her dogs are also a source of enjoyment for her...". Review of 01/13 Medication Administration Records (MARs) revealed the resident had an order for, and received on 15 occasions, "[redacted] ([redacted] medication)... PRN (as needed) (for) [redacted]" In an interview on 02/13/13 at 10:45 a.m., Staff D (Nurse Manager) stated it was the expectation nursing staff attempt non drug interventions prior to the administration of PRN [redacted] medications and the interventions should be documented in the progress notes. In an interview on 02/14/13 at 8:28 a.m., Staff N (Medical Records) indicated the computer program the facility was using had the ability to direct staff to document the existence of behaviors, interventions attempted and outcomes. Staff N confirmed that for Resident #17, staff failed to create the codes which would cue staff to document the resident demonstrated a target behavior, or that non drug interventions were attempted. Upon reviewing the electronic record, Staff N confirmed staff documented in the progress notes the resident demonstrated [redacted], but there was no evidence of non-drug interventions. Failure to consider non-pharmacological interventions,	F 329,	As noted there were progress notes to substantiate rationale for medication administration. Residents EMAR now reflects interventions to be attempted prior to administering an Anti-anxiety. Resident was admitted on 1/3/13, while resident was in the ER, Xanax was initial prudent approach to address extreme anxiety that resident was prone to due to her acute tragic loss of her daughter on Christmas Eve and her home burning down on Christmas. Resident identified this medication as the first approach and as she acclimated to facility began requesting less. Non-pharmacological approach were not the first approach given the context of her individualized Care Plan and statements by resident. Resident # 279 is no longer in residence. RECEIVED JUN 25 2013 DSHS/ADSA/RCS	

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instead of, or in addition to, [redacted] medications placed the resident at risk to receive an unnecessary medication.

Additionally, according to the MAR, staff monitored for side effects of the [redacted] Resident #17 was receiving on a daily basis. Side effect symptoms included, "[redacted]." There was no indication on any of the 13 days the resident received PRN [redacted] medication, staff identified the resident experienced what was described as a side effect of the [redacted] medication.

RESIDENT #279
According to the 01/16/13 MOS, Resident #279 had no trouble falling or staying asleep or sleeping too much. The resident did indicate feeling tired or having little energy on one of the past seven days. This resident was discharged and unavailable for observation or interview.

Review of current Physician Orders (PO)s revealed Resident #279 received [redacted] (a [redacted] medication) every night for "[redacted]" from 01/09/13 to [redacted]/13, the date of discharge. There was no assessment regarding the resident's sleep patterns, type of [redacted] (difficulty falling asleep vs staying asleep), possible causes for insomnia or attempted non drug interventions prior to the initiation of the routine [redacted]

According to the "Nursing 2009 Drug Handbook" utilized by facility staff as a drug reference, Nursing considerations included, "Use [redacted] only for short-term management of insomnia,

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F 329	Continued From page 23 the record staff re-evaluated the continued need of this medication once it was started. According to the Care Area Assessment (CAA) associated with the 01/18/13MOS, the Resident reports not sleeping during the night, wants to sleep dL1ring day time." There was no indication facility staff considered the resident's desire to sleep during the day or that the [redacted] administered every night might interfere with the stated desire to sleep during the day. According to 02/13 sleep monitor documents, the resident consistently slept between 8.5 and 13.5 hours each day. There was no indication staff assessed how much sleep the resident required, m if the number of hours the resident slept was adequate. RESIDENT #126 According to the 01/18/13 MOS, the resident had no mood/psychiatric disorders. The resident was assessed to have behaviors on one to three of the past seven days, but none which impacted the resident's care/social interactions or placed the resident at significant risk for injury. Staff did determine the residents behaviors put others at significant risk for physical injury. According to this MOS, English was not the resident's primary language and the resident needed an interpreter to communicate with a doctor or health care staff. Record review of CP documents dated 01/11/13 indicated Resident #126 had [redacted] related to [redacted]. The CP indicated the resident had "[redacted]," which is a potential side effect of taking [redacted] medications. Record review also indicated Resident #126 had	F 329	Resident # 126 currently has non-pharmacological interventions for use of anti-anxiety. Although justification given in Progress Notes, E-MAR did not provide means to document. This has been addressed RECEIVED JUN 25 2013 DSHS/ADSA/RCS	

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orders for and received PRN [redacted] for [redacted] and [redacted] for [redacted].

In an interview on 02/14/13 at 9:15 a.m., Staff N confirmed no "intervention" or "outcome" orders were entered into the computer, thus staff were not pron:pted to attempt or document non drug interventions prior to the administration of the PRN psychotropic medfcations.

According to 01/13 MAR, staff identified the resident exhibited the following behaviors: agitation, angry, anxiety, compulsiveness, screaming/yelling, fighting, hallucination/delirium, kicking, noisy, restlessness, scratching, hitting, resistive". However, there was no identification of individualized non drug interventions which should be attempted prior to the administration of the medi ations, nor was there any delineation as to what behavior required the use of which medication. While staff monitored numerous behaviors, there was no distinction between behaviors which required [redacted] versus [redacted].

Additionally, per the MAR, the resident received nine doses of PRN [redacted] in the month of January. For seven of nine doses staff failed to document which behavior the resident demonstrated which required the use of the medication. Upon review of the electronic record on the morning of 02/14/13, Staff N confirmed there was no evidence to support facility staff attempted any non drug interventions prior to the administration of the PRN medications.

RESIDENT #23
Review of POs revealed the resident received [redacted] for [redacted] every night since

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04/20/12. Staff monitored the resident's hours of sleep each shift. Review of the 12/12, 01/13 and 02/13 sleep monitors revealed the resident was noted to consistently sleep seven hours each night and an additional three to five hours during the day.

Review of the resident's comprehensive CP revealed no mention of insomnia.

In an interview on 02/13/13 at 9:45 a.m., Staff C stated the resident complained of ongoing insomnia at each care conference She also stated the resident's family member did not want her taken off the. [redacted] as "she has always taken tons of [redacted] medications."

Staff C referenced a care conference note dated 01/08/13 in which the resident complained of insomnia, little energy, and feeling tired. Staff C stated the resident remains in bed most of the time and that she might lie in bed with her eyes closed. Staff C stated the sleep monitor might not be accurate, as staff assume she is asleep but perhaps she isn't. Staff C further explained a gradual dose reduction had not been considered because [redacted] "isn't a psych med."

Failure to consider non drug interventions and to ensure accurate monitoring in order to determine continued need of the medication placed the resident at risk to receive unnecessary drugs.

RESIDENT #11
According to the 12/07/12 MOS, Resident #11 was assessed with a mood score of one, indicating minimal [redacted]. Diagnoses included [redacted] and [redacted].

F 329

Meletonin is considered an herbal supplement supplement. Insomnia was not triggered by MDS for Care Planning purposes. Medical problems are no longer routinely Care Planned but driven off the CAA summary and patient needs.

There is ongoing documentation in the treatment sheet, with hours of sleep regarding effectiveness of Melatonin for sleep. Daughter or resident in Care Conference has confirmed long history of Insomnia and has been pleased with a "non-drug intervention".
Per Resident and family choice this herbal supplement will continue to be offered and effectiveness documented.

Resident #11 was reviewed by the Psychotropic Medication Multidisciplinary Team on 12/12/12 with a recommendation to consult with Physician and family regarding current medication regimen related to Mood/Depression. In a note by Primary Physician on 1/11/13 indicated "Anxiety due to likely behavior component with vascular dementia continue Citalopram as patient well controlled on this regimen". The MD attempted a GDR on Seroquel but decided to continue with Citalopram as above. Family is also noted to have been involved with these decisions.

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Review of Resident #11's record revealed the resident received the [redacted] 30 mg daily since 06/09/11.

The 09/17/12 Behavioral symptoms CAA indicated the mood score was one related to resident feeling bad about herself occasionally in the last two weeks. The CAA noted the resident "wishes she was better but couldn't be more specific. Primary Care Physician currently managing psych meds." Neither the Behavioral symptoms CAA nor the Psychotropic Drug Use CAA addressed a Gradual Dose Reduction (GDR) of the antidepressant.

In an interview on 02/14/13 at 11:27 a.m. Staff L was unable to find either recommendations for a GDR or history of an at1:empted GDR.

RESIDENT #42
Record review revealed Resident #42 received the medication [redacted] (a medication used to treat [redacted] problems) since 12/02/09 for [redacted]. There was no monitoring of effectiveness of the medication and no evaluation of the continued need of its use. According to the "Nursing 2009 Drug Handbook", there were time parameters for this medication and, according to the record, the resident did not demonstrate symptoms which required it's continued use. In an interview on 02/14/13 at 9:48 a.m. Staff C indicate the pharmacist makes monthly recommendation to the physicians and "she always writes [redacted] (as needing reduced). I'm really surprised she didn't catch that". Staff C was unable to find a pharmacy recommendation related to the [redacted] or evidence it's

On 1/23/13 Resident # 42 was assessed by the Hospice Team "assessed medication effectiveness and patient/caregiver confidence in medication used to manage symptoms". There were no recommendations to discontinue Omeprazole.

The need for any medications or supplements offered residents is an Multidisciplinary approach which may include physicians, pharmacists, mental health professionals, specialists, nursing judgment based on Physician Order and in coordination with resident and family.

Unit Managers monitor as lead member of a team.
DNS ensures intent of the regulation is in compliance.
The facility ensures that it is free of medication error rates of five percent or greater

2-14-13
And
On-going

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F 329	Continued From page 27 continued use was considered.	F 329,		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5%. Four of five Licensed Nurses (Staff J, K, 0 & P) failed to follow physician's orders and/or manufacturer's recommendations for four of 51 medications observed, which resulted in a medication error rate of 7.8% with four (#s 18, 62, 153 & 124) of ten residents reviewed experiencing medication errors. These failures placed residents at risk to experience adverse side effects or less than the intended therapeutic effects of medications. Findings include: RESIDENT #18 During observation of medication pass on 02/13/13 at 11:10 a.m., Staff J prepared medications for Resident #18. Staff J was observed to retrieve a bottle of cranberry tablets (450 milligrams each) from the medication cart. The bottle was open and dated 02/05/13. Staff J poured the medication. Upon review of the physician's order (PO), Staff J noted 200 mg of cranberry supplements was to be administered stating, "I can't cut this in half." Staff J looked in house supply and medication storage but was	F 332,	Cranberry tablets are an herbal supplement. The LN did call the Physician who indicated the order could be written "per house supply" which as done on 2-13-13, to ensure dosage matches Physicians Order. RECEIVED JUN 25 2013 DSHS/ADSA/RCS	

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F 332	Continued From page 28 unable to locate any cranberry tablets which were 200 mgs. Staff J stated, "maybe we used to have house supply 200 mg but they maybe switched to 450 mg." Staff J conferred with Staff D who indicated the cranberry tablets were house supply and one tablet should be administered. Staff J was then observed to administer the medication. Staff J later reported, after conferring with Central Supply staff, that 450 mg had been the house supply dose for "quite a while" and staff were not administering the 200 mg according to POs. This constituted one medication error.	F 332		
	RESIDENT #62 During observation of medication pass on 02/14/13 at 7:20 a.m., Staff K prepared and administered multiple medications including a [redacted] for Resident #62. Staff K was observed to administer the resident's nasal spray in the right nare. Record review revealed the computerized POs directed staff to administer this medication to the left nare. In an interview at 7:40 a.m., Staff K stated there were no clear directions directing which nare to administer the medication on which day, just that the site should be "alternating". Staff K further elaborated, "I ask the resident, she can tell me which side was done the day before." Staff D, at 7:50 a.m. was able to identify there was an area on the PO which directed staff which nare to use and confirmed Staff K did not follow POs. This constituted one medication error.		Resident #62's nurse who administered the nasal spray had given the same medication the day prior to the to the alternate nare. The electronic record now includes clarifying directions to ensure that anyone giving the nasal spray would be aware of each daily area of administration.	
	RESIDENT #153 During observation of medication pass on		Resident #153's available cream corresponds with Physicians Order.	

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02/13/13 at 8:31 a.m., Staff O administered [redacted] 0.1% cream to Resident #153's left [redacted] and [redacted]. Review of the POs directed staff to apply [redacted] 0.025% cream. In an interview on 02/13/13 at 10:42 a.m. Staff O looked in the medication cart and said "Oh, this is the one he gets from the VA," pointing to a tube with a pharmacy label for named resident which was 0.025%. She then compared it with the cream she had applied, "house supply" which was 0.1%, and commented, "This is not the right one." This constituted one medication error.

RESIDENT #124
During observation of medication pass on 02/13/13, Staff P drew 15 units of [redacted], which was verified audibly and visually and administered in Resident #124's left abdomen. Review of the POs revealed the resident was ordered to receive [redacted] 17 units. In an interview on 02/13/13 at 10:38 a.m. Staff P said "I give it every morning he gets 17, it was a miscommunication ...". This constituted one medication error.

F 332

Resident # 124 receives 17 units of Humalog Insulin. Staff P administers this resident's AM medication Monday through Friday. Staff P stated that she must have been misunderstood, by the observer, when asked the amount, she gave the resident 17 units and documented same.
The LN who was observed had given 15units to another resident during medication pass but not resident #124. LN was unaware of any errors as this was not communicated.
All LN's are in-serviced regularly by Pharmacy Nurse and Pharmacist regarding appropriate medication administration.
Unit Managers monitor for compliance. DNS is responsible for ensuring compliance

F 364 SS;;E 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP

Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview the facility failed to ensure residents received food that was

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served at appropriate temperatures and consistency to maintain food quality, palatability and attractiveness. Seven (#s 14, 110, 108, 268, 201, 35 & 218) of the 17 residents interviewed during Stage 1 voiced concerns about the temperature, taste, or look of the food served. Observations and interviews during Stage 2 further revealed concerns about the taste and consistency of the food served. These failures placed all residents at risk for decreased quality of life, compromised nutritional status, and potential weight loss.

Findings include:

RESIDENT INTERVIEWS

In an interview on 02/08/13 at 2:07 p.m., Resident #14 stated the food served to her wasn't "always hot." She further explained she "might order soup or something it's not hot. You expect it to be hot it is barely warm, sometimes when it comes to the table it isn't' really hot."

In an additional interview on 02/13/13 at 12:56 p.m., Resident #14 stated "sometimes the milk is colder than others, sometimes it's just a little below room temperature ...". She stated eggs at breakfast were "never really hot, by the time they get to us they aren't (hot)...".

In an interview on 2/08/13 at 1:17 p.m., Resident #11O stated food served was often "cold" and "bland.',.

Resident #268, in an interview on 02/11/13 at 9:12 a.ni., stated the food was often bland, with no taste. In addition, he stated it was often not hot when served.

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Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor and appearance; and food that is palatable, attractive, and proper temperature.

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In an interview on 02/11/13 at 9:32 a.m., Resident #201 stated food served was often neither appetizing nor warm.

TEMPERATURE

Observation of the lunch tray line on 02/12/13 revealed all foods were present on the steam table by 11:47 a.m. Staff started serving lunch at 12:10 p.m. and the last tray was prepared at 12:48 p.m. Observation of the 2 West Hall trays on 02/12/13 at 12:48 p.m. revealed Staff R and Staff S put pre-poured beverages, including milk and orange juice, onto the resident room trays. The pre-poured beverages were noted sitting on trays on a table in the 2 West Dining Room. They were not on ice or otherwise kept cold. Similar observations were noted on 02/07/13 at 12:27 p.m. in the 2 East Dining Room where the pre-poured beverages were sitting on trays out on the counter, not on ice.

On 02/12/13 a test tray was requested and at 1:10 p.m., after the last resident was served, temperatures and consistency were assessed. The milk temperature was 58.5 degrees Fahrenheit (F) and when consumed the top portion of the milk was warm, whereas the middle appeared cooler, but not cold. The lemonade was 62.1 degrees F and felt lukewarm. The pureed pork with gravy measured 128 degrees F with a texture which was glue/rubber like. The pureed vegetables were 121.7 degrees F. While they tasted like broccoli, they were spicy hot.

In an interview on 02/13/13at10:30 a.m. Staff W said the facility changed the beverage system following the test tray. He stated the kitchen

F 364

Temperature of food and beverages is an ongoing challenge, related to complex circumstances. There are residents who want trays left and they will eat them when they choose, for example. There are microwaves on each unit, NAC's offer to heat items that residents may want a warmer temperature. The facility instituted de-centralized dining so food did not need to be transported, residents are served directly off a steam table. Temperature logs are kept in each dining room to ensure proper temperatures. The facility also questions residents regularly through our internal quality assurance practices to ensure their input regarding temperature. Beverages are no longer pre-poured and chilled but kept on ice in containers for pouring in the Dining Room.

The staff have been in-serviced regarding residents preferences and since the steam tables are in the dining rooms it is convenient to request alternate items, or items not on their tray, in a timely matter.
All residents cited have been re-interviewed by facility staff and any concerns addressed.

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would now send cups for staff to pour beverages from pitchers, which were kept on ice.

RESIDENT #108
Resident #108, in an interview on 02/08/13 at 2:08 p.m. stated food was "lukewarm by the time it" was served in her room. She stated staff frequently removed the lid from the plate before she was ready to eat, which caused the food to lose it's heat quickly.

On 02/11/13 Resident #108 was served a room tray for lunch. In an interview at 12:42 p.m. Resident #108 said she had asked Staff V to bring her a salad and she had not been served a salad as requested with her tray.

Review of the resident's record revealed a 01/26/13 Dietician Visit/ recommendation which indicated the resident "would like to add salads... Also states that the staff are very helpful and want to "set up" trays by removing lids, resident prefers to leave lid on food to maintain temperature... wants to keep portions the same for her meals but add salads."

In an interview on 02/14/13 at 12:47 p.m. StaffY indicated she added a dinner salad to the

resident's tray card according to a 12/10/12 Resident Food Preference Form, but had not added a salad to the lunch meal after the 01/26/13 visit. In addition, StaffY concluded the staff may not have brought the salad as requested because listed on the tray card was "no raw vegetables."

In an interview on 02/14/13 at 9:34 a.m. regarding the breakfast served, Resident #108 said, "They

The facility has addressed the concern of "attractiveness of pureed meals" by including on the cited 2 East Units, the use of brightly colored Fiesta Ware. This has greatly enhanced presentation. Furthermore, all menus are reviewed to assure that similar colored foods are not served together and meals are garnished properly.
All dietary staff have been in-serviced on temperatures, attractiveness and consistency of pureed/mechanical textures, as well as how to substitute appropriately.

Food Service Manager will monitor compliance, the Dietician will ensure compliance.

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F 364!

'forgot to bring me a glass of milk." When asked why she had not eaten the hot cereal served, Resident #108 replied, "I didn't eat it because I they didn't send any butter." The tray card instructed staff to serve "sugar free syrup for hot cereal" which also was not sent.

In an interview on 02/14/13at12:47 p.m. Staff Y indicated condiments, including margarine and milk, came from the nursing assistants when served.

Similar findings were noted on 02/07/13 at 12:42 p.m. for Resident #137 who had a tray card which indicated the resident preferred "lunch half sandwich" and "built up silverware and scoop dish." The resident was observed with neither the listed sandwich or the described adaptive devices. Similar findings were identified at the lunch meal on 02/08/13.

ATTRACTIVENESS
Observations of the lunch meal on 02/07/13 in the 2 East Dining Room revealed Resident #s 7 and #126 were served a plate that consisted of one white scoop shaped pile covered with greenish brown colored gravy. Similar observations were noted on 02/08/13 at 8:25 a.m. in which residents receiving pureed diets were served on a white plate, two scoops/piles of food, one white in color and the other brown. Pureed meals did not appear appetizing or attractive.

According to the Week 2 Tuesday menu, a Regular/Mechanical Soft diet was to receive 1/2 cup of "Diced Carrots." During tray line on 02/12/13 at 11:56 a.m. the cook, Staff AA was observed to serve what appeared to be pureed

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carrots. When asked, Staff AA said "We didn't have diced carrots."

On 02/12/13at1:24 p.m. Staff W concurred the mechanical soft vegetable should have been diced carrots. Staff Y said mechanical soft should be vegetables which can be mashed with a fork rather than pureed with no particles, like baby food.

The facility failed to serve the appropriate mechanically altered therapeutic diet during lunch on 02/12/13 which decreased the attractiveness and palatability of the meal.

F 364

The facility procures food from sources approved or considered satisfactory by Federal, State or local authorities; and stores, prepares, distributes and serves food under sanitary conditions.

F 371 483.35(i) FOOD PROCURE,
SS=D STORE/PREPARE/SERVE - SANITARY

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

F 371

This REQUIREMENT is not met as evidenced by:
Based on observation and interview the facility failed to store, piepare and serve food under sanitary conditions. This failure created the potential for food contamination for all residents receiving food prepared by the dietary department.

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F 371	Continued From page 35 Findings include: FOOD STORAGE Observation of the kitchen during the initial tour on 02/07/13 at 8:08 a.m. revealed the following: A bin of sugar was observed open with an open bag of s.ugar inside. In the walk-in refrigerator, containers of prunes dated 2/3, cut up lemons dated 1/29, and grapes dated 2/3 were observed. In an interview on 02/08/13 at 9:08 a.m., Staff W indicated that after 72 hours, Time and Temperature Sensitive (TTS) foods, including proteins, cut fruit and ready to eat foods should be discarded. At that time, the cut up lemons dated 1/29 were still in the refrigerator. Staff W said "cut fruit is one of the TTS so that should have been gone." The grapes were still present and observed with some moldy grapes in the lower corners of the container which Staff W discarded. In addition, nectar thick milk dated 2/4 was observed which Staff W said "yesterday was the last day" and discarded. FOOD SERVICE On 02/08/13 at 8:25 a.m. food service was observed in the 2 East Dining Room. Staff BB was observed, while wearing gloves, to pick up toast and place it on the resident's plates without the use of tongs. At 8:32 a.m. a nursing assistant was observed to flip through the paper tray cards barehanded. She licked her finger and continued to thumb through the cards before placing the	F 371	The Moldy Grape, 3 slices of Lemon and 1 day expired thickened milk was disposed of during tour of walk –in refrigerator. Staff will be in-regarding outdated items in walk in. Food Service Manager will monitor for compliance. Dietician to ensure compliance	

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F 371 , Continued From page 36

cards back on the table where Staff BB picked up one tray card, placed the tray card on the tray, and picked up toast and placed it on the resident's plates with the same gloved hand repeatedly. Five different nursing staff members were observed to handle the paper tray cards intermittently though tray line prior to being handled by Staff BB.

At 8:37 a.m. Staff BB was observed to pick up two empty bowls holding the inside of each bowl before filling with cereal for a resident's consumption, wearing the same gloves.

At 8:45 a.m. Staff BB was observed to turn off all the burners and then, still wearing the same gloves, served a bowl of food, retrieved two pieces of bread and cut them in half. At 8:46 a.m. Staff BB picked up the clip board with the temperature log, put the thermometer in a bag and then removed the soiled gloves.

Similar observations were noted during lunch tray line on 02/12/13 regarding the paper tray carc;ls in which Staff W handed the tray cards which had handwritten preferences to Staff AA who placed them on one surface and later moved them to another surface. During tray line Staff AA picked up each individual tray card, read it, and placed it on the tray prior to serving the residents' food. In an interview on 02/12/13 at 1:00 p.m. Staff R indicated the nursing assistant assigned room trays took the tray cards to each resident to obtain their choice for the meal and then sent the cards to the kitchen.

On 02/12/13, Staff R was observed to pass room trays on 2 West. Staff R failed to wash her hands

F 371

All staff will be in-serviced regarding proper handling of utensils, how to minimize handling of tray cards, as well as proper tray delivery to resident rooms.

All managers in dining room will monitor compliance of sanitary conditions in food service.
Administrator will ensure compliance

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on-going

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F 371	Continued From page 37 or perform hand hygiene between residents. For example, outside Resident #258's room was a posted sign to "Check with nurse before entering." Staff R knocked on the door, entered, and walked through the closed privacy curtain with the lunch tray. The breakfast tray was sitting on the bedside table which Staff R picked up with her right hand, then placed the lunch tray down with her left hand. She removed a banana and sandwich from the breakfast tray and placed them on the lunch tray, then walked out of the room through the privacy curtains, and placed the soiled tray on top of the tray cart. Staff R proceeded to serve the next resident, including pouring hot chocolate without hand hygiene. In room 214 Staff R cleared the bedside table of the resident's belongings before placing the tray and cued the resident by touching the resident's hand. Staff R was observed to pass nine hall trays from 12:48 p.m. until 1:10 p.m. without performing hand hygiene.	F 371		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet	F 425		

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the needs of each resident.

The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review it was determined the facility failed to ensure medications were available and/or administered as ordered for two residents (#s 287 and 67) and failed to clarify and/or follow Physician's Orders for six residents (#s 18, 17, 165, 124, 42 & 279). Additionally, staff failed to ensure a system by which injection/patch sites were rotated for seven residents (#s 110, 219, 165, 23, 279, 42 & 126). These failures placed residents at risl< for untreated medical conditions, medication errors and pain related to repeated injections in the same location.

Findings include but are not limited to:
Refer to CFR 483.25(m)(1), F-332, Medication Error Rate

FAILURE TO ORDER/HAVE MEDICATIONS AVAILABLE

RESIDENT #287
Record review revealed a progress note dated 02/04/13 which indicated, "vitamin D (ergocalciferol) medication not available." In an

F 425,

The facility provides routine and emergency drugs and biologicals to it's residents, obtain them under an agreement described in 483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State Law permits, but only under the general supervision of a Licensed Nurse.

3-18-13
and
ongoing

The facility provides pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.
he facility employs or obtains the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.

Resident # 287 is not on a care unit, nor floor that Staff D oversees. Thus it would seem understandable she would not have the answer to the question about Vitamin D available pertaining to this resident. The resident has been receiving daily Vitamin D as documented.

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I interview on 02/14/13, Staff D was requested to determine why Resident #287 did not have regularly scheduled medications available. No information was provided.

RESIDENT #67
Observation of medication pass on 02/13/13 revealed Staff J at 8:15 a.m. was unable to administer the Omeprazole as it was not available. During an interview at that time, Staff J stated, "the pharmacy delivers the medication the night it is ordered (and it was ordered yesterday) so it should be here." At 8:25 a.m., Staff J stated she spoke with the pharmacy, who never received an order for the Omeprazole.

Record review revealed the original physician's order (PO) was never noted, which would have entailed a signature by Licensed Nursing staff reflecting the order was acknowledged, transcribed into the Medication Administration Record (MAR) and ordered from the pharmacy. Staff J indicated she was unable to administer the intended medication because facility staff failed to order it from the pharmacy.

FAILURE TO CLARIFY/ADMINISTER PER POS
RESIDENT #18
Observation of medication pass on 02/13/13 at 11:10 a.m. revealed Staff J prepare medications, including a 450 milligram (mg) tablet of cranberry for Resident #18. Review of POs revealed the resident had an order for cranberry 200 mg. During an interview on 02/13/13 at 2:26 p.m., Staff J stated the PO, "has been like this for awhile." Staff J also stated the facility had not carried the 200 mg cranberry for "a long time." Staff J also indicated the order should have been

The ARNP was in late (3:25pm) on 2/12/13 to see patient and wrote an order to decrease Omeprazole from 20mg to 10mg. The order was sent too late for AM delivery, but the medication would be available that day. The LN called the ARNP who ordered the 20mg to be continued, the resident did not miss a dose according to the MAR. The physicians order was carried out correctly.

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The order for Cranberry Tabs reflects "administer dose per house supply". Licensed Nurses are in-serviced to ensure that orders for house supply of herbal supplements and vitamins are clarified for appropriate dosage.

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clarified to reflect the amount of house supply medication actually being administered. Failure to clarify the order resulted in the resident receiving an unintended dose for an undetermined length of time.

RESIDENT #17
Review of 02/13 MARs r.evealed facility staff were to administer "Vitamin 03... tid (three times a day)." Review of the MAR did not reflect the physician's original order for "Vitamin 03... each day." While staff did administer this medication correctly one time per day, there was the potential for a medication error g:ven the incorrect transcription. In an interview on 02/13/13, Staff H at 10:20 a.m. stated "staff should have clarified that (the MAR)."

RESIDENT #165
Review of Consolidated POs and the January and February MARs revealed an order that read: "[redacted]e... twice a day... Hold for SBP (systolic blood pressure)< (less than) 110, DBP (diastolic blood pressure) < 60, and HR (heart rate) <60." The original PO, dated 01/22/13, indicated the parameters should be "hold for systolic BP <110, diastolic BP <60, heart rate< 60", which meant if any one of the three parameters was less than noted, the medication should be held. In an interview on 02/14/13 at 9:56 a.m., Staff C stated the order was transcribed incorrectly. She stated staff transcribed the comma as the word "and" when it should have read "or". As it was written, staff gave the medication on multiple occasions when one or two of the parameters were low. Staff D acknowledged staff sho.uld have held the medication and clarified the order with the

F 425

Licensed Nurses have been in-serviced regarding blood pressure parameters and blood sugar parameters related to documentation of Resident # 165 and #42, and to ensure EMAR reflects accurately the medication administration and physicians orders for Resident #17 and #124. Residents #110, 165,and #126 have had the EMAR corrected to include a space for documenting site used for each injection. As facility utilizes consistent staffing the Licensed Nurses are familiar with site rotations for their specific residents. New EMARS reflect appropriate areas to provide specific instructions and documentation.

All Licensed Nurses have been in-serviced. Unit Managers monitor medication administration, pharmacy also monitors physicians orders monthly. DNS to ensure compliance.

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F 425

physician.

Resident #165 also received [redacted] with the order "hold for SBP <110." Review of the January MAR revealed staff administered the medication seven times between 01/21/13 and 01/28/12 when the SBP was less than 110. Staff C acknowledged the medication was given when it should have been held.

RESIDENT #124

During medication administration observation on 02/13/13, Resident #124 received a 1,000 mg capsule of Fish Oil. The 06/06/12 PO indicated one capsule of Fish Oil should be given twice a day. The order did not indicate what dose of Fish Oil should be given, as it is available in numerous doses. In an interview on 02/13/13 at 10:35 a.m., Staff P stated the Fish Oil was a house supply and that the order should have been clarified.

RESIDENT#42

Review of the January MAR revealed Resident #42 was to receive [redacted] twice a day. Staff were directed to hold the [redacted] and notify the ARNP if her blood sugar was "below 100." According to the MAR, at 8:00 a.m. on 01/23/13 and 01/24/13 the resident's blood sugar was less than 100 and staff documented administration of the [redacted]. Review of progress notes revealed the [redacted] was not documented as held and the physician was not notified on 01/23/13 or 01/24/13 as ordered.

RESIDENT #279

Review of 01/13 MARs revealed on 01/12/13 the resident had a blood sugar of 196 and should have received one unit of [redacted]. Staff

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I documented the resident received no insulin. In an interview on the morning of 02/14/13, Staff N confirmed the resident should have received one unit of insulin.

In an interview on 02/14/13 at 12:34 p.m. Staff B indicated the LNs were expected to follow the physician's orders.

FAILURE TO DOCUMENT SITE ROTATION

FACILITY POLICY
According to the facility's "Subcutaneous medication administration" policy, staff were to "Document the injection on the MAR/TAR along with site used (page 109)." The Intramuscular medication Administration policy similarly directed staff to, " Document the injection on the MAR along with site used...".

RESIDENT #110
Record review revealed Resident #11O received [redacted] (IM) [redacted] of [redacted] from 01/18-24/13. Review of the computerized record revealed no indication on the MAR or in the progress notes of the location of the IM [redacted]. In an interview on 02/14/13, Staff N indicated because of the way the order was entered into the computer, there was no space or cue for staff to document the [redacted] site.

Similar findings were identified for Resident #219, who received daily subcutaneous injections of Procrit without staff documentation of injection site, which placed the resident at risk for repeated injections in the same

site. RESIDENT #165

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Resident #165 received a sliding scale dose of [redacted] up to three times a day. Review of the January and February I'v1ARs revealed staff failed to document the [redacted] site. In an interview on 02/14/13 at 10:01 a.m., Staff C stated staff should record the injection site and was unaware the computer system did net have a place for it.

Similar findings were noted for Resident #23 for whom staff documented the [redacted] site but not the amount of [redacted] given for a sliding scale order. In addition, staff failed to document the [redacted] site for [redacted] which was administered twice a day. Staff C stated staff should record the [redacted] site and for a sliding scale order, should document the number of units administered.

Similar findings were identified for Resident #279 for whom staff documented repeated [redacted]s in the same site without rotation. Similar findings were noted for Resident #42 for whom staff documented [redacted] as given in the same site for consecutive [redacted] doses on 01/26/13, 01/27/13, 02/05/13, 02/06/13 and 02/12/13 8:00 p.m. dose and 02/13/13 7:30 a.m. dose. In an interview on 02/14/13 at 12:36 p.m., Staff B indicated the [redacted] site should be rotated each time the [redacted] was given.

RESIDENT#126
Review of 02/13 POs revealed Resident #126 received a medicated [redacted] every day and staff were directed to document the site administered. According to Drugs.com, "The used patch should be removed and a new one applied to a different skin site at the same time each day." Review of 02/13 MARs revealed staff did not consistently rotate application sites, often

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	the facility policy for [redacted] application specified "right" or "left" chest. Also, staff documented the patch was applied to site "73" when no such location was indicated for patch application.			
	In an interview on 02/14/13 at 9:15 a.m., Staff N confirmed the patch rotation was unclear and inconsistent.			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431,	The facility employs the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	2-14-13 and ongoing
	The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.		Drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	
	Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.		All expired medications were disposed of on 2/7/13, this is an on going process and monitored on a routine basis by Unit Managers and the Pharmacy Consultants. The Director of Nursing ensures compliance with the disposal of out dated medications	
	In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.			
	The facility must provide separately locked, permanently affixed compartments for storage of			

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F 431

Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to ensure drugs and biologicals were labeled, dated and/or disposed of when expired in accordance with currently accepted professional standards and facility policy. This failure was identified on six of eight medication carts and one of four medication rooms reviewed and placed residents at risk to receive expired medications.

Findings include:

FIRST FLOOR
Observation on 02/07/13 at 8:56 a.m. of the 100-1 Medication Cart revealed the following: A vial of [redacted] for Resident #165 dated as opened 01/07/13. According to Staff 0, insulin was good for 28 days after being opened. She stated the vial should be discarded. A vial of [redacted] for Resident #173 was dated as opened 01/05/13.

Observation on 02/07/13 at 9:03 a.m. of the 100-2 Medication Cart revealed a vial of Lantus insulin dated 01/05/13. At that time, Staff P stated the vial should be discarded as it was expired.

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	505017		02/14/2013

NAME OF PROVIDER OR SUPPLIER
WASHINGTON CENTER FOR COMPREHE

STREET ADDRESS, CITY, STATE, ZIP CODE
2821 SOUTH WALDEN STREET
SEATTLE, WA 98144

(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 431 Continued From page 46

F 431

In the 100 Medication Room refrigerator, a vial of [redacted] for Resident #165, dated as opened 01/08/13 and a vial of [redacted] for Resident #135, dated as opened 01/01/13, were located. Staff P, at 9:18 a.m., stated she did not know why these opened and expired vials were stored in the refrigerator.

SECOND FLOOR
During initial rounds on *02107*/13, observation of the 2 West "team 2" medication cart revealed [redacted] for Resident #268, dated as opened 01/05/13, with a note to discard 28 days after opening. Staff I said "We have to throw that away."

Observations of the "team 2" medication cart on 2 East revealed a vial of [redacted] for Resident #92 which was dated as opened 01/07/13 and a note to discard after 28 days. Staff CC commented it was "two days late."

THIRD FLOOR
During initial rounds on 02/07/13, observation of the third floor "team 2" medication cart revealed insulin for Resident #22, which was dated as opened 01/02/13 with an expiration date written as 01/30/13.

Observations of the third floor "team 1" medication cart revealed eye drops for two residents (including Resident #73) which were opened and undated.

F 514 483.75(1)(1) RES
SS=D RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

F 514

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F 514 Continued From page 47

The facility must mainta.in 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 preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to ensure a system in which resident's records were complete and accurate. Failure to ensure documents, including care plans, assessments, and care guides were complete, accurate and readily accessible placed residents at risk for unmet needs.

Findings include:
CFR 483.20(k), F279, Develop Comprehensive Care Plans
CFR 483.25(1)(1), F329, Unnecessary drugs
CFR 483.60, F425, Pharmacy Services

RESTORATIVE NURSING PROGRAM
RESIDENT #20
Review of Resident #20's record revealed she was to receive a Restorative Nursing Program (RNP), to include [redacted] and [redacted]. In an interview on 02/14/13 at 8: 10 a.m., Staff B stated the program should be offered six days a week and that Resident #20

F 514

The facility maintains clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.
3-8-13
and
on-going

The clinical record contains sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.
3-8-13
and
on-going

RA Program has been re-evaluated for resident # 20 for a program designed more to resident preference given her refusal to participate with RAs.

RAs have been in-serviced on the importance of following RNP Care Plans consistent and accurate documentation. Restorative Coordinator will monitor documentation.
DNS will ensure compliance.

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F 514, Continued From page 48	frequently refused. Review of RNP documentation revealed the resident was offered the program only 11 times in the past 30 days. Staff B stated the resident was offered the program as ordered however staff failed to consistently document her refusals.	F 514		

RESIDENT #268
Review of Resident #268's record revealed he was to receive a RNP to include Sit to Stand at the parallel bars for three reps. Review of the RNP documentation indicated the resident was performing 30 repetitions. In an interview on 02/14/13 Staff U said, "He stands in the bars three times... I got confused, I mixed that up with the Range of Motion."

RESIDENT #108
Review of Resident #1OS's record revealed she was to receive a RNP to include application of a splint to the [redacted] hand with a goal of two hours on then remove. Review of the RNP documentation revealed no documentation of splint application or duration of splinting.

PHYSICIAN ORDERS
RESIDENT #165
Review of Resident #165's February Medication Administration Record revealed an order for "[redacted]... twice a day Everyday; BID (twice a day), Every 8 hours...". In an interview on 02/13/13 at 10:18 a.m., Staff C stated the MAR was inaccurate and it "should not say every eight hours."

The MAR for Resident #165 was modified, medication was being given correctly, schedule was correct but wording entered incorrectly. Inventory Lists for Resident #165 and #108 were reviewed and updated.

INVENTORY LISTS
The Personal Belongings Sheet (PBS) located in Resident #165's chart was not signed or dated by

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F 514	Continued From page 49 the resident or staff. In addition, it did not include all the items observed in the resident's room. Review of Resident #1OS's record revealed a PBS dated 12/05/12 which was blank, unsigned and did not include any belongings. A different PBS, dated 07/03/12, which was attached to a lost items report listed only one undershirt. Observation of the resident's room revealed a multitude of personal items.	F 514	To reflect current personal items, Resident's families are encouraged to inform staff per policy when items are brought in.	
	ASSESSMENTS RESIDENT #50 According to the 12/22/12 Minimum Data Set, Resident #50 was assessed with a [redacted] (full thickness tissue loss) [redacted] The 01/13/13 Actual alteration in skin integrity Care Plan (CP) related to [redacted] pressure ulcer listed interventions including "Skin MD (specialist) sees res(ident) weekly to monitor wound". There were no wound assessments present in the resident's record. In an interview on 02/11/13 at 1:55 p.m. Staff C said the wound assessments were kept in a separate binder. According to Staff C, when wounds healed the skin sheets were moved to the "resolved Skin issues" section of the binder and were not placed in the resident's record. She stated the assessments completed by the pl·1ysician were copied and given to Medical Records, but the skin team assessments were not.		Wound assessment sheets are available on request, and were provided to surveyor immediately. As a part of a QA process these wound sheets are not required to be in the chart. Wound summaries are completed by the LN and wound physician on a weekly basis and located in the record. The requested "Wound Sheets" were obtained from Master Wound Book not on the "computer or e-mail" at the time of request. Weekly head to toe assessments are completed by the Primary LNs and assessments kept in the chart also.	

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F 514	Continued From page 51 bathing, Staff F said "I have not done anything specifically." Review of the nursing assistant bathing documentation in the resident's record revealed bathing "did not occur" from 01/16/13 through 02/13/13. In an interview on 02/14/13 at 1:14 a.m. Staff H said the primary aid told the nurse the resident refused the shower on 02/05/13 so she gave the shower the next day on 02/06/13. The resident also refused on 02/12/13. Staff H said the aid did not document the showers as offered and refused nor did the aid document the shower as given "because she was not assigned to it." Failure to document refusals and provisions of showers left the facility unable to assess reasons for refusals and determine if the resident's needs were being met.	F 514	Unit Manager confirmed that resident #268 received his shower per his request. This documentation is in the electronic record that the NAC completed for resident. NACs have been in-serviced as a reminder to ensure documentation for all their residents. Unit Managers will monitor compliance. DNS ensures compliance	
		F999	This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability or wrongdoing on the part of the facility, nor does it constitute any specific agreement with statements of fact and conclusions as presented in the statement of deficiencies.	

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