

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/09/2016
NAME OF PROVIDER OR SUPPLIER WASHINGTON CENTER FOR COMPREHE			STREET ADDRESS, CITY, STATE, ZIP CODE 2821 SOUTH WALDEN STREET SEATTLE, WA 98144		
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F 176 SS=D	<p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to ensure residents were assessed for safety of self-administration of medications, including assessment, determination of safety, storage at bedside, and monitoring for one (#177) resident observed with medications at bedside.</p> <p>Findings include:</p> <p>A review of the facility's Self Administration of Medication policy, dated 02/23/12, indicated staff would explain the procedure to the resident and type a list of the resident's medications. Staff were also to review doses and the indication for use of each medication, instruct the resident to notify the nurse for their medications at the appropriate time, and document in the Self-Administration medication record. The policy did not include a procedure for the control and safe storage of medications for those residents who could self-administer medications.</p> <p>According to the Minimum Data Set (MDS) assessment dated 04/18/16, Resident #177 admitted to the facility on [REDACTED]/16 with multiple medical diagnoses. This MDS indicated the resident was able to make her needs known.</p>	F 176		7/20/16	

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F 176	<p>Continued From page 2</p> <p>On 06/01/16 at approximately 9:30 a.m., during the initial tour of the facility, a bottle of Magnesium (oral supplement) was observed on the resident's dresser in her room. On 06/06/16 at 10:00 a.m., an observation was made with Staff D in which the same bottle of Magnesium was observed, unsecured, on the resident's dresser. During the same observation Resident #177 informed Staff D that her daughter assisted her with taking the Magnesium.</p> <p>Staff D stated the resident was not currently on a self-medication program. Staff D stated the resident had not been assessed for possible drug interactions or the ability to properly store/secure and safely administer medications.</p> <p>On 06/09/16 at 8:01 a.m., an observation was made with Staff N of a bottle of liquid Magnesium on the resident's night stand. Staff N informed the resident that she would have to speak to Staff D and discuss how the facility would proceed with keeping medications at her bedside.</p> <p>A review of a progress note dated 06/06/16 at 2:46 p.m. revealed staff met with the resident regarding medications left at the resident's bedside. According to Staff D, the facility was unaware the medication had been left at the resident's bedside, although they were in plain view. Staff D stated Resident #177's daughter was responsible for bringing the medication to the facility and leaving it at the resident's bedside without informing facility staff.</p> <p>Failure to monitor and assess residents for self-administration of medications placed residents at risk of adverse effects from medication interactions, overdose and</p>	F 176			

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F 176	Continued From page 3 exacerbation of medical conditions.	F 176			
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified	F 225		7/20/16	

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F 225	<p>Continued From page 4 appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to ensure a resident's fall with injuries was thoroughly investigated in order to rule out neglect. Failure to base conclusions on facts and include relevant interview for one (#75) of six residents reviewed for falls placed the resident at risk for additional falls, injury and neglect.</p> <p>Findings include:</p> <p>According to a progress note, dated 04/24/16, staff documented Resident #75 reported she "hurt all over" and had fallen. When assessed by a Licensed Nurse, a [REDACTED] was found on the resident's [REDACTED] area [REDACTED]. She was sent to a hospital emergency room for further evaluation.</p> <p>When Resident #75 was asked by staff about details of her reported fall, she was unable to recall the location, date, time or other circumstances of the fall. Staff documented the resident gave three different explanations about her fall. According to staff, two of the three statements she made included comments she had been helped to get up by one or more people after she fell.</p> <p>On 06/08/16, the facility's investigation of this incident was reviewed. An initial document completed by the nurse on duty on 04/24/16 stated the location of the resident's fall was</p>	F 225		

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F 225	<p>Continued From page 5</p> <p>unknown. Staff also documented in a 04/24/16 progress note that the time of the resident's fall was not known, and the resident reportedly gave multiple accounts of the fall, once saying "the guy helped me up" and later "two people get me up" [sic].</p> <p>The investigation did not identify key facts about the fall (date, time, location, presence of other staff/ witnesses). However, when staff who completed the "Unwitnessed Fall Investigation" were asked "Was the floor clean/ dry and free of clutter hazards", she circled "yes", with no further explanation.</p> <p>When asked "Were the lights on in the room or area where the fall occurred?", staff again responded "yes" without any further clarification. When asked "What kind of footwear was the resident wearing?" Staff checked both "shoes" and "socks". Without direct observation of the resident and her location at the time she fell, none of this information could be conclusively known.</p> <p>Further review of the investigation revealed two brief statements by nurse aides assigned to assist Resident #75 were included. Each statement said the resident had not fallen during their shift, even though staff would not be with any resident during the entire shift. There was no interview with a family member who, according to staff, visited the resident during day shift. There were also no interviews with other care givers (night shift staff working the morning of 04/24/16 or therapy staff who were working with the resident) to determine if they had observed the fall or anyone assisting the resident after she fell.</p>	F 225			

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F 225	Continued From page 6 There was no information found regarding follow up interviews with Resident #75, to determine if she could describe who had helped her up after she fell. Without information to discern if facility policies were followed by staff (such as notifying a licensed nurse when a resident fell and having the resident assessed by a licensed staff prior to moving them after a fall) the investigation did not address the facility's duty to rule out potential neglect as a factor in this resident's injury. On 05/09/16 at 09:45 a.m., the facility's investigation of this incident was reviewed with Staff B, who had signed that the investigation was complete. It was discussed the information documented in this investigation was not factual and did not include interviews with others in order to address and rule out the potential for neglect as a factor in the resident's injury.	F 225			
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, interview and record review it was determined that the facility failed to respond to one (#56) resident's request for incontinence care in a dignified manner. This resident told staff she had been [REDACTED] of urine five times during a period of 65 minutes, before she was provided with [REDACTED] care.	F 241		7/20/16	

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F 241	<p>Continued From page 7</p> <p>This failure to respond to the resident's repeated requests for incontinence care in a timely and respectful manner placed the resident at risk for physical discomfort, skin breakdown and a diminished sense of self-worth.</p> <p>Findings include:</p> <p>RESIDENT #56 According to the Minimum Data Set (MDS) assessment, dated 04/14/16, Resident #56 admitted to the facility on [REDACTED] 16 with care needs related to dementia, impaired mobility and other medical conditions. This MDS revealed she required extensive assistance from staff for transfers and toileting. The current care plan, dated 05/25/16, indicated Resident #56 was to be checked for [REDACTED] every 2 to 3 hours and as needed, and provided [REDACTED] care by staff.</p> <p>On 06/06/16 at 8:16 a.m., Resident #56 was seated in a wheelchair in the 2 East dining room (DR) waiting for breakfast. The resident told Staff F, a Restorative Aide (RA), she was "wet" [REDACTED] and needed to be changed. Staff F told the resident she would go tell another Nursing Assistant, and exited the DR.</p> <p>At 8:22 a.m., Resident #56 remained in the DR and was served her meal tray by Staff F. Observations from 8:22 a.m. until 8:36 a.m. found Resident #56 drank coffee and fed herself cereal. At 8:55 a.m., Resident #56 was moved from the DR next to a medication cart in an adjacent hall, where she again said to staff, "I'm wet... I need to change my diaper." Staff who were with the resident did not acknowledged her request.</p>	F 241		

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F 241	<p>Continued From page 8</p> <p>At 9:00 a.m., Staff F was in the room with Resident #56 and cued her to do oral care. When Staff F talked about doing exercises with the resident, Resident #56 again asked if she was going to get help to get her brief changed. Staff F replied, "Yes, as soon as I am done."</p> <p>At 9:10 a.m., as Staff F prepared to transfer the resident from her wheelchair to bed, Resident #56 asked her a fourth time about help getting her wet [REDACTED] brief changed. Staff F responded "I know, you need to take care of that...", but did not offer to provide this care or ask another staff to assist the resident. As a Restorative Aide, Staff F was also a Certified Nursing Assistant (CNA) who had the training and experience to provide incontinence care for residents.</p> <p>At 9:15 a.m., Staff F completed transferring the resident into bed and covered her with a sheet, without offering to provide incontinence care.</p> <p>At 9:20 a.m., Staff F washed her hands at the sink and prepared to exit the room. During this time, Resident #56 made a fifth request for care, saying to the RA, "I hope they come change my diaper like they said." It had been over an hour since the resident first told the RA she had been incontinent and needed care.</p> <p>At 9:23 a.m., a CNA entered the room and provided incontinence care, an hour and 7 minutes after the resident first notified staff she had been [REDACTED]</p> <p>On 06/08/16 at 11:20 a.m., during an interview with the Nurse Manager (Staff G), he was asked about Resident #56's care plan regarding toileting</p>	F 241			

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F 241	Continued From page 9 and incontinence care. He stated staff had attempted to toilet this resident when she moved to his unit, but this was discontinued because she was asking staff for help with toileting every 30 to 60 minutes. Staff G was asked when staff would be expected to help a resident who stated they needed to be changed, as observed on 06/06/16. He replied he would expect a resident to be assisted within 5-10 minutes, depending on the circumstances (e.g. if staff was helping another resident). When the above observations of Resident #56's repeated requests for incontinence care to Staff F were described, Staff G did not respond initially. When asked if RAs were also CNAs, and trained and capable of providing [REDACTED] care, Staff G replied "Yes." On 06/09/16 at 8:40 a.m., Staff G was asked if the actions of Staff F not providing Resident #56 with the care she requested was consistent with the facility's policies regarding responding promptly and respectfully to residents. He replied, "No."	F 241			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to identify and provide necessary maintenance and housekeeping services in resident rooms,	F 253		7/20/16	

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F 253	<p>Continued From page 10</p> <p>hallways, and to maintain a functional call light system. Failure to maintain or complete repairs in a timely manner did not provide residents with safe, sanitary conditions and did not create a homelike environment for residents to live in and placed residents at risk for decreased quality of life, compromised dignity, and potential infection control issues.</p> <p>Findings include:</p> <p>Observations on 06/01/16 during initial rounds in the morning revealed broken blinds in room [REDACTED]. Also noted were multiple patched areas on the wall in room [REDACTED] which had not been repainted to match the rest of the room. Multiple chairs in the third floor activity room were noted to be soiled/stained with a white substance and remained in that condition throughout the survey. The hallway window outside of room [REDACTED] was cracked, with tape placed over the crack in the window.</p> <p>Observations during initial rounds on 06/01/16 at 8:56 a.m. revealed multiple patched areas beneath the resident names posted outside room 318 which had not been repainted to match the rest of the wall. Window treatments with approximately 10 bent slats on the right and four on the left were noted in room 318 as well as missing paint on the walls behind the beds. Rooms 309 and 312 also had bent window treatment slats. The bathroom door in room 321 was scraped. Room 310 contained a chair with white staining.</p> <p>Observations on 06/07/18 and 06/08/16 at 8:15 a.m. revealed the first floor dining room had a burnt out ceiling light. In an interview on 06/08/16</p>	F 253		

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F 253	<p>Continued From page 11</p> <p>at 9:48 a.m., Staff I, Maintenance Director, stated "We changed the light bulb on that one." However, a later observation at 1:50 p.m. revealed the ceiling light remained burnt out.</p> <p>Observation on 06/08/16 at 8:23 a.m. revealed a second floor hallway window with duct tape holding broken glass in place. The window was soiled with dirt and dust combined with cobwebs. There was duct tape on a portable air conditioner attached to the window which was coming loose.</p> <p>In an interview on 06/08/16 at 9:52 a.m., Staff I stated, "The window will be replaced. I can show you the paperwork."</p> <p>Record review of a work proposal submitted by Staff I on 06/08/16 at 11:00 a.m. indicated the facility obtained an estimate from a glass company to "Supply and install broken insulated glass unit on the 2nd floor. Reset 2 units block 46" x 60" that are falling out on the 3rd floor." The work proposal dated 05/23/16 included an estimate but did not indicate a timeframe for completion. The proposal noted the facility must have an "Established account or fifty percent (50%) deposit required to proceed with the work outlined in this proposal."</p> <p>On 06/03/16 at 8:44 a.m., observation of the 2 East activity room found a red plastic-covered couch with multiple dried spills/ streaks present on the arms and front of it. The seats of four other chairs in this room also appeared soiled and in need of cleaning.</p> <p>Further observations on 06/06/16 at 11:45 am and 06/09/16 at 12:10 p.m., revealed the couch and multiple chairs in this activity room were</p>	F 253			

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F 253	<p>Continued From page 12</p> <p>soiled with dried spills/ splatters and in need of cleaning. At 12:15 p.m., on 06/09/16, Staff I was asked to observe the condition of the furniture. When asked about a schedule for cleaning the furniture, he commented it was old and hard to keep clean. As he and a housekeeper used cloths and a cleaning solution to wipe off the couch, the areas of dried spills were removed.</p> <p>Observation on 06/08/16 at 8:27 a.m. revealed room 211 had an unfinished wall which needed paint. The windows in rooms 207, 208, 211, and 212 did not have screens and there were insects on the window sills. Room 210 had a table in disrepair revealing protective foam coming apart from around the edges. Room 212 had broken blinds. Room 268 had bent blinds. The second floor window across from the elevator had screens which were not fitted properly. Two second floor dining room windows did not have screens and were broken or not fitted properly. The third floor window across from the elevator did not have a screen.</p> <p>In an interview on 06/08/16 at 9:55 a.m., Staff I stated there was a cleaning crew onsite to wash and repair all of the building's windows. Staff I said some of the screens were removed for cleaning. Regarding the condition of blinds, Staff I stated, "The residents bend some of the blinds."</p> <p>CALL LIGHT SYSTEM Visual and auditory observations on 06/01/16, 06/02/16, 06/03/16, 06/06/16, 06/07/16 and 06/08/16 revealed a faulty display panel for the first floor call light system. When the call lights were tested, a buzzer behind the nurse's station sounded but the signal lights were out of order for the following rooms: 106, 112, 113, 115, 120 and</p>	F 253			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/09/2016
NAME OF PROVIDER OR SUPPLIER WASHINGTON CENTER FOR COMPREHE			STREET ADDRESS, CITY, STATE, ZIP CODE 2821 SOUTH WALDEN STREET SEATTLE, WA 98144		
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F 253	Continued From page 13 122. An observation on 06/02/16 at 9:22 a.m. revealed a buzzer sounding for approximately 10 minutes. The hallway call light from room 122 was lit. The buzzer at the nurse's station continued sounding but the indicator light was not on. In an interview on 06/08/16 at 9:42 a.m. Staff I stated the facility maintained a log for needed repairs. He said, "The call lights, overhead lights... they have to be replaced right away or we notify electrical company." When asked if he was aware of any problems with the first floor call system, Staff said "No, this panel is the only one that give us a lot of issues. There are some areas that are being replaced. We are working. We have three rooms that are like that right now. 103 and 116. The dining room, the bathrooms are connected. It just happened this year that we are constantly. We need to replace the whole circuit board."	F 253			
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine;	F 272		7/20/16	

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F 272	<p>Continued From page 14</p> <p>Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to accurately assess eleven (#s 34, 60, 197, 120, 159, 162, 88, 2, 70, 44 & 156) of the eighteen sampled residents whose Minimum Data Set (MDS) assessments were reviewed in Stage 2. Failure to accurately identify a limited life expectancy; communication ability; dental status; behaviors; and skin condition placed residents at risk for unmet needs.</p>	F 272			

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F 272	<p>Continued From page 15</p> <p>Findings include:</p> <p>HOSPICE RESIDENT #34 Resident #34 admitted to the facility on [REDACTED] 15 with multiple complex medical diagnoses. According to Section J of the 02/20/16 and 05/20/16 MDSs, the resident did not have a diagnosis that would result in a life expectancy of less than six months. However, the O section of the MDS indicated the resident required Hospice services, indicating the resident had a life expectancy of less than six months.</p> <p>According to the Resident Assessment Instrument User's Manual (directions to staff on how to complete MDS assessments), staff are instructed to document the resident's life expectancy is less than six months if "the resident is receiving hospice services."</p> <p>In an interview on 06/08/16 at 8:26 a.m., Staff H stated, "I will have to call the MDS person who did this and get back to you to see why they coded it this way...". Staff H later indicated these MDSs were incorrect and should have reflected the resident had a life expectancy of less than six months.</p> <p>RESIDENT #60 According to the 09/25/15 MDS, Resident #60 did not have a condition or chronic disease that would result in a life expectancy of less than six months, but did require the services of Hospice related to end of life care. Similar findings were identified for the 03/26/16 MDS. In an interview on 06/09/16 at 9:15 a.m., Staff H indicated the MDS was incorrect and that additional staff training was required.</p>	F 272			

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F 272	Continued From page 16 RESIDENT #197: Resident #197 admitted [REDACTED] 16 with care needs related to a [REDACTED] condition. According to the initial MDS dated 02/24/16 (Section J1400), Resident #197 did not have a condition or chronic disease that would result in a life expectancy of less than six months, but according to Section O, he received Hospice services related to a terminal condition. Similar findings were identified for the 05/23/16 MDS. In an interview on 06/08/16 at 10:55 a.m., Staff H indicated this coding of the MDS was incorrect. COMMUNICATION: RESIDENT #120: Resident #120 admitted [REDACTED] 15 with care needs related to kidney failure and dialysis. Review of the most recent MDS assessment, dated 03/01/16, revealed this resident communicated in an unidentified language other than English. Under Section B of the MDS, which documented the extent to which a resident could communicate with and understand others, staff documented Resident #120 was "Understood" and "Understands others - clear comprehension". However, in Sections C and D of this same MDS, which assessed the resident's memory and mood, staff documented Resident #120 was "Never/rarely understood" so was not interviewed for either of these assessments. RESIDENT #159 Resident #159 admitted in [REDACTED] 14 with care needs related to dementia, a history of [REDACTED] and other chronic conditions. Review of the most recent MDS assessment dated 04/01/16 revealed this resident communicated primarily in two [REDACTED]. Under Section B, which	F 272			

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F 272	<p>Continued From page 17</p> <p>documented the extent to which a resident could communicate with and understand others, staff documented Resident #159 was "Usually understood" and "Understands others". However, in Sections C and D of this same assessment which assessed the resident's memory and mood, staff documented Resident #159 was "Never/rarely understood" so was not interviewed as part of this assessment.</p> <p>RESIDENT #197 Resident #197 admitted [REDACTED] 16 with care need related to a [REDACTED] condition. When observed on 06/02/16 and 06/03/16, he could occasionally answer "Yes" or "No" questions, but was unable to communicate other needs to staff.</p> <p>Review of the MDS assessments dated 02/24/16 and 05/23/16 revealed under Section B, staff documented Resident #197 was "Usually understood" and "Understands others". However, in Sections C and D of this same assessment, which assessed the resident's memory and mood, staff documented Resident #197 was "Never/rarely understood" so he was not interviewed as part of this assessment.</p> <p>RESIDENT #162 Resident #162 admitted [REDACTED] /15 with care needs related to dementia, impaired speech and mobility as the result of a [REDACTED]. Efforts to talk with this resident on 06/01/16 and 06/02/16 revealed the resident was unable to respond verbally. Review of the most recent MDS dated 04/18/16 revealed this resident's primary language was [REDACTED]. Under Section B, staff documented Resident #162 was "Usually understood" and "Understands others". However, in Sections C and D, which</p>	F 272			

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F 272	<p>Continued From page 18</p> <p>assessed the resident's memory and mood, staff documented Resident #162 was "Never/rarely understood" and was not interviewed.</p> <p>RESIDENT #88 Resident #88 admitted to the facility in [REDACTED]/10 and according to the 03/03/16 MDS, had diagnoses including Alzheimer's disease and dementia. According to this MDS, under Section B, staff documented Resident #88 was "Usually understood" and "Understands others". However, in Sections C and D, which assessed the resident's memory and mood, staff documented Resident #88 was "Never/rarely understood" and was not interviewed.</p> <p>STAFF INTERVIEW: On 06/08/16 at 10:55 am, the MDS Coordinator (Staff H) was interviewed about the above inconsistent responses. Sections B, C and D for each resident as well as the inconsistent responses between the resident's ability to communicate in Section B versus each resident's inability to complete basic assessments about their memory and mood was reviewed. Failure by different staff who completed these sections of the MDS to coordinate their responses was identified by Staff H as a contributing factor.</p> <p>DENTAL RESIDENT #34 Resident #34 admitted to the facility on [REDACTED] 15 with multiple complex medical diagnoses. Observation on 06/01/16 at 1:52 p.m. revealed the resident had heavy white debris in the lower gum line beneath what appeared to be broken and/or carious teeth, white debris in gum line and the gum line was shrunk back below teeth. According to the 5/20/16 MDS, the resident was</p>	F 272		

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F 272	<p>Continued From page 19</p> <p>assessed to have "obviously or likely cavity or broken natural teeth" and was also assessed by staff to be edentulous. In an interview on 06/08/16 at 8:24 a.m., Staff H stated, "She is not edentulous." Staff H indicated this section of the MDS was incorrect.</p> <p>RESIDENT #2 Observation on 06/02/16 at 11:46 a.m. revealed the resident had what appeared to be inflamed gums and [REDACTED] teeth that were darkened.</p> <p>An 12/17/15 Oral Dental Status Assessment (ODSA) revealed staff assessed Resident #2 with obvious or likely cavities. According to a dental consult dated 02/05/16, Resident #2 was assessed with multiple broken and missing teeth and dental decay. An ODSA dated 03/17/16 also reflected the resident had obvious or likely cavities.</p> <p>According to the most recent MDS dated 03/24/16, Resident #2 was assessed to have no obvious or likely cavity or broken natural teeth, contrary to the 12/17/15, 02/05/16 and 03/17/16 dental assessments.</p> <p>In an interview on 06/09/16 at 9:16 a.m., when asked about the difference between the dental assessment, current observations and the MDS assessment, Staff H referred to the ODSA forms and said, "This is what I go by." Staff H confirmed the MDS was incorrect regarding the resident's dental status.</p> <p>RESIDENT #88 Observation on 06/02/16 at 8:54 a.m. revealed the resident had receded and inflamed gums, white debris in the gum line and areas of</p>	F 272			

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F 272	<p>Continued From page 20</p> <p>darkened teeth.</p> <p>Resident #88's 06/11/15 and 08/28/15 ODSAs indicated the resident had "obvious or likely cavity" but the subsequent 06/16/15 and 09/02/15 MDSs indicated no obvious or likely cavities. The 11/26/15 ODSA reflected the resident had "obvious or likely cavity" but the 12/03/15 MDS indicated the resident had no obvious or likely cavity or broken natural teeth, contrary to the ODSA performed less than a week before.</p> <p>According to a Care Area Assessment (CAA) dated 12/03/15, "This CAA triggered due to resident with loose upper partial dentures, causal and risk factors-resident is at risk for chewing/swallowing oral pain related to loose upper partial, dementia etc...". While staff documented the resident, "...denies any issues with other natural teeth..." staff failed to indicate if an assessment was completed or if the resident had broken/carious teeth as previously assessed.</p> <p>According to the ODSAs performed on 02/16/16 and 5/28/16, staff were unable to perform the dental assessment. The 03/03/16 MDS reflected the resident had "broken or loose dentures" but didn't reflect the resident was unable to assess the resident's dental status.</p> <p>In an interview on 06/09/16 at 9:16 a.m., Staff H was asked about the difference between the dental assessments and the MDS assessments. Staff H indicated there should be an assessment which identified the resident had no carious teeth, or the MDS should reflect staff were unable to complete the oral assessment.</p> <p>RESIDENT #70</p>	F 272			

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F 272	<p>Continued From page 21</p> <p>Observations of Resident #70 during meals on 06/01, 06/02, 06/03, 06/06, 06/07 and 06/08/16 revealed the resident lying down while eating. Observations revealed the resident remained in bed most of the time.</p> <p>According to the MDSs dated 02/15/16 and 05/15/16, the resident did not refuse care during the 7 day look back periods of these assessments.</p> <p>Review of progress notes revealed the following related to care refusals: On 02/07/16, the resident refused pain medication; On 02/08/16, the resident refused repositioning twice; On 02/10/16, the resident refused to eat dinner and refused pain medication three times. The resident refused repositioning three times. The resident refused to be weighed three times; On 02/11/16, the resident refused all medications except one. He also refused to eat dinner and a supplement twice. The resident refused repositioning three times; On 02/12/16, the resident refused his meals and refused repositioning. The nurse offered a pain medication and he refused it; On 02/13/16, orders were noted for IV fluids and the resident refused them. The resident refused to be repositioned every two hours; On 02/14/16, the resident refused to eat dinner. He was encouraged to take a pain medication but the resident refused it three times. On 02/15/16, the resident refused to eat. He accepted his antibiotics and insulin but refused the rest of his medications. The resident also refused a vital signs check.</p>	F 272			

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F 272	<p>Continued From page 22</p> <p>Progress notes from 05/01/16 to 05/15/16 also indicated the resident had frequent care refusals.</p> <p>In an interview on 06/06/16 at 8:02 a.m. the resident acknowledged staff offered to reposition him every two hours. He said staff have talked with him about concerns regarding his eating, positioning and bathing.</p> <p>In an interview on 06/07/16 at 9:20 a.m. Staff E, Social Services, stated the previous social worker who completed the MDS assessment no longer worked at the facility. Staff E stated she was employed a month ago and completed the most recent MDS assessment dated 05/15/16. When asked what information she reviewed to make a determination regarding care refusals, staff stated, "Mainly the MAR (Medication Administration Review)." Staff E stated she did not know about the 7 day look-back period for the MDS. Staff E stated she did not review the resident's progress notes from 05/08/16 to 05/15/16 to accurately complete the recent MDS assessment.</p> <p>RESIDENT #44 Similar findings were identified for Resident #44 whose 04/02/16 MDS indicated the resident did not have any behaviors related to care refusals. Nurse progress notes dated 03/26, 03/27, 03/28, 03/29, 03/30 and 03/31/16, revealed the resident refused to get out of bed, to attend activities, medications, to go to her doctor's appointment and to have vital signs taken. None of these refusals were identified on the MDS.</p> <p>RESIDENT #156 Resident #156 admitted to the facility in [REDACTED] 14 with diagnoses to include Bullous Pemphigoid (a</p>	F 272		

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F 272	<p>Continued From page 23</p> <p>rare skin condition that causes large, fluid-filled blisters).</p> <p>In an interview on 06/01/16 at 1:13 p.m., Staff Q, Nurse Manager, was asked if Resident #156 had one or more pressure ulcers. Staff Q responded, "No" then indicated the resident had multiple ruptured blisters to the buttocks that were a result of Bullous Pemphigoid.</p> <p>Record review revealed a progress note dated 05/12/16 at 6:36 a.m. written by Staff Q that stated, "resident has three more blisters in the inner buttocks ruptured, currently on hydrocolloid q (every) 3 days and as needed, order is updated to include the newly opened blisters. Resident has dx (diagnosis) of [REDACTED] and is on [REDACTED] no blisters have been noted on other areas of the body...".</p> <p>Review of Resident #157's 01/07/16 "Recurrent [REDACTED] Blisters" care plan revealed a new goal was initiated on 05/16/16, "resident's open blisters to inner buttock will heal; resident has dx of [REDACTED] that causes the eruption of blisters."</p> <p>When asked on 06/07/16 at 12:43 p.m. Staff Z (physician) confirmed that he diagnosed the blisters identified on 05/12/16 as [REDACTED]</p> <p>Review of the 05/18/16 MDS revealed the resident was assessed with moisture related tissue damage and section 1040D "open lesion(s) other than ulcers rashes and cuts" was not checked. Per the Resident Assessment Instrument, [REDACTED] should be coded under 1040D.</p>	F 272			

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F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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 assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to develop and/or revise comprehensive care plans for four (#s 2, 177, 156 & 56) of the 18 residents whose care plans were reviewed in Stage 2. Failure to establish care plans that were individualized, accurately reflected assessed care needs and provided direction to staff related to adaptive devices, ADLs (Activities of Daily Living), non pressure skin conditions and pain placed</p>	F 279		7/20/16	

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F 279	<p>Continued From page 25</p> <p>residents at risk to receive less than adequate care.</p> <p>Findings include:</p> <p>RESIDENT #2 According to the 03/24/16 Minimum Data Set (MDS) assessment, Resident #2 had diagnoses of dementia and [REDACTED] was dependent on staff for Activities of Daily Living (ADLs) and had functional limitation in range of motion for both upper and lower extremities on one side.</p> <p>According to Mobility Care Plans (CPs) with target dates of 06/25/16, staff were directed to "monitor skin integrity (every) shift related to left U/L (upper/lower) splint use; report redness, skin breakdown, or pain to LN (Licensed Nurse) while resident is wearing the splints, placed by RA." Another intervention directed staff to apply splints to the resident's right upper and lower extremities. According to the "Nurse Aide's Information Sheet" located in the resident's closet, the resident was to have "Special splint" but gave no further instructions to staff as to the type of splint or how it was to be applied.</p> <p>Observation on 06/02/16 at 11:24 a.m. revealed the resident had a splint with metal supports applied to the [REDACTED] lower extremity and [REDACTED] boot to the [REDACTED] foot. However, observations on 06/07/16 at 10:42 a.m., 11:31 a.m., 12:30 p.m. and 1:28 p.m. revealed the resident in his w/c (wheelchair) with a metal splint to the [REDACTED] leg and a soft blue boot to [REDACTED] foot. Similar observations of splints applied to the right upper and lower extremities were noted on 06/08 and 06/09/16.</p> <p>In an interview on 06/08/16 at 7:25 a.m., Staff Q</p>	F 279			

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F 279	<p>Continued From page 26</p> <p>(Nurse Manager) indicated the CP was incorrect and the splints should be applied to the resident's [REDACTED] upper and lower extremities, not the [REDACTED]. Failure to ensure the CP accurately reflected the assessed needs placed the resident at risk for having improper splint placement.</p> <p>RESIDENT #177</p> <p>According to the 04/13/16 MDS, Resident #177 admitted to the facility on [REDACTED]/16. This MDS assessed the resident with multiple diagnoses including [REDACTED] and pain.</p> <p>On 06/07/16 at 10:05 a.m., Resident #177 stated she had [REDACTED] disease [REDACTED] [REDACTED] and experienced pain in her hands especially in cold temperatures. According to the resident, her hands were often cold and she often asked the staff to wrap her hands in a blanket to keep them warm.</p> <p>In an interview on 06/08/16 at 9:38 a.m., Staff D stated she was unaware of the resident's complaints of pain or discomfort related to her hands. Staff D stated to her knowledge there was no mention of the resident having [REDACTED] disease or complaints of pain in her hands related to changes in the temperature in the record. According to Staff D, she was aware the resident had deformed joints in her hands, but failed to document her observations stating "she (Resident #177) had so many other issues when she admitted we felt she wasn't going to live."</p> <p>On 06/08/16 at 12:26 p.m., Staff B (Director of Nursing) stated the expectation was the nurse</p>	F 279		

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F 279	<p>Continued From page 27</p> <p>would document any form of joint deformity or complaints of painful joints on the initial assessment so it could be adequately care planned.</p> <p>During the same interview, Staff B was asked to make an observation with the surveyor of the resident. Resident #177 was observed in bed with her hands wrapped in a blanket. Resident #177 informed Staff B that she requested the blanket because her hands were cold and she needed the blanket to keep her hands warm.</p> <p>According to Staff B, the facility failed to address the resident's joint deformities "when a resident is dying our focus is pain not range of motion or therapy." A review of the resident's plan of care revealed no documentation related to the resident's complaints of pain in her hands or the deformed joints.</p> <p>The facility's failure to assess the resident for painful hands and joint deformities or to develop a plan of care instructing staff to keep the resident's hands warm to prevent pain or discomfort and or the potential need for range of motion services placed Resident #177 at risk for decreased quality of life related to pain and discomfort.</p> <p>RESIDENT #156 Resident #156 admitted to the facility in [redacted] /14 with diagnoses to include a [redacted] with [redacted] and muscle weakness. According to the 05/16/16 MDS assessment, the resident was assessed to be seldom understood with severe cognitive impairment and required total two person assistance for bed mobility, transfers, dressing and toileting. He had diagnosed functional limitation to range of motion of his [redacted]</p>	F 279		

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F 279	<p>Continued From page 28</p> <p>arm and leg.</p> <p>According to Resident #156's "Bedside Kardex Report" dated 08/28/15, located on the resident's closet door, staff were directed to "Ensure I (resident) am wearing [redacted] and splint which are alternating to both my [redacted] [redacted]. No direction was given as to when the [redacted] were to be applied e.g. in bed, when up in wheelchair or when they were to alternate.</p> <p>Resident #156's "Skin at Risk" CP dated 02/22/16 directed staff to "Encourage and assist to turn every two hours. After each turn assure heels are not touching and are floated (elevated off mattress); avoid skin to skin contact whenever possible" but did not mention or direct the use of [redacted] [redacted].</p> <p>The "Nurse Aides Information Sheet" also located in the resident's closet, directed staff to turn and reposition the resident every two hours but gave no direction to float heels or apply "blue boots."</p> <p>Observations of Resident #156 on 06/06/16 at 7:33 a.m., 8:15 a.m. and 9:42 a.m. revealed the resident lying in bed without heels floated. A blue boot was noted in a chair at the resident's bedside. Similar findings were noted on 06/07/16 at 8:09 a.m., 9:58 a.m. and on 06/08/16 at 9:36 a.m.</p> <p>On 06/08/16 at 1:09 p.m. Staff Q was asked which document the nurse aides should follow and when the resident should have the [redacted] [redacted] applied. Staff Q responded, "I think this is an old one, it should be removed (referring to the "Bedside Kardex Report")." Staff Q removed it</p>	F 279			

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F 279	<p>Continued From page 29</p> <p>from the closet door at that time. When asked if the resident required his heels to be floated when in bed, as the CP stated but the "Nurses Aide Information Sheet" did not, Staff Q stated "I will clarify."</p> <p>In addition, observations on 06/02/16 at 10:51 a.m.; 06/03/16 at 11:30 a.m., 12:21 p.m., 12:57 p.m., 1:21 p.m., 1:43 p.m., and 2:01 p.m.; and on 06/06/16 at 11:18 a.m. and 12:04 p.m. revealed Resident #156 sitting up in a wheelchair reclined to approximately 45 degrees. The resident's [REDACTED] forearm was secured to the arm trough on the wheelchair with [REDACTED] [REDACTED] straps.</p> <p>Review of the resident's care plans, consents, physician orders (PO's), assessments, Physical Therapy (PT) and Occupational Therapy (OT) notes revealed no documentation Resident # 156 was assessed to have a medical symptom that required the use of Velcro straps to secure the resident's arm to the arm trough.</p> <p>During an interview with Staff V (Director of Rehabilitation) on 06/06/16 at 12:10 p.m. documentation was requested that supported the use of the straps. Staff V stated, "The record shows no indication the trough straps were recommended or implemented by therapy. I have never placed straps on an arm trough." Staff V further acknowledged that there was no assessment for the use of the trough straps or plan of care for their use.</p> <p>Review of an OT note dated 02/25/16 at 3:43 p.m. revealed Staff U (OT) documented "Next Session:... train morning nurse and CG (caregiver) and RA (restorative aide) for applying appropriately the strap of the arm trough to [REDACTED]"</p>	F 279			

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F 279	<p>Continued From page 30</p> <p>█████ arm to promote skin integrity... DNS (Director of Nursing Services) was called by this therapist and showed indentation on the █████ wrist area (posterior side) where the strap of the arm trough was applied." This note demonstrated facility staff were aware the straps were being utilized. Subsequent OT notes did not address or mention the use of the straps. Further documentation was requested on 06/06/16 however, none was provided.</p> <p>On 06/07/16 at 9:04 a.m., Staff Q, Nurse Manager, was interviewed about the use of the straps and acknowledged Resident #156's █████ arm was being secured to the arm trough when up in the wheelchair. He said, "I am not sure why they (straps) are there, the resident recently transferred from another floor." Staff Q acknowledged there was no mention in the care plan of the use of the straps.</p> <p>The facility's failure to establish and maintain accurate CPs which reflect the resident's current care needs, and provide clear direction to staff as to how the resident should be positioned and what adaptive equipment should be used, placed this resident at risk to receive less than adequate care.</p> <p>RESIDENT #56: Resident #56 admitted to the facility █████/16 with care needs related to dementia █████ issues, impaired mobility and █████ █████ Review of the current care plan last revised on 05/27/16 identified Resident #56 as being assisted by staff to use the toilet ("1 person extensive assist to toilet, bedside commode or bed pan as needed.").</p>	F 279		

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F 279	Continued From page 31 Observation of this resident's care on 06/06/16 and 06/07/16 revealed she was not taken to the toilet and no commode was present in her room. During an interview with the Nurse Manager (Staff G) on 06/08/16 at 11:45 am, he stated the resident was no longer being toileted, which was not revised in her current care plan.	F 279			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure one (#156) of three sample residents reviewed for pressure ulcers received the necessary care and services for non-pressure skin issues to attain or maintain their highest practicable level of well being. Failure to clearly identify, assess and monitor non-pressure skin issues placed the resident at risk for declining skin conditions. Findings Include: NON-PRESSURE SKIN Per the facility's 11/29/13 "Skin Integrity Maintenance and Healing" Policy, staff were directed to complete weekly skin	F 309		7/20/16	

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F 309	<p>Continued From page 32</p> <p>assessments, document the findings in the Weekly Skin Progress Notes and complete Non Pressure Flow Sheets for monitoring of identified skin issues. In addition, staff were directed to obtain physician's orders for treatments and initiate a short term care plan. The licensed nurse in charge of the resident's care would initiate and complete the Weekly Skin Report on a weekly basis, and forward the report to the DNS (Director of Nursing Services) or designee, until resolved.</p> <p>The wound assessment and documentation would include: measurements (length, width, depth in centimeters); presence of drainage to include type, odor, amount and color; wound bed description to include necrotic tissue, slough, granulation, tunneling, undermining; description of peri-wound area; presence or absence of pain; and presence or absence of infection and /or edema. Additionally, the policy directed staff to notify the physician and DNS if there was a lack of progress after 30 days of treatment and to immediately notify the physician if the wound increased in size/depth or developed any sign of infection.</p> <p>RESIDENT #156 Resident #156 admitted to the facility in [REDACTED] 14 with diagnoses including [REDACTED] with [REDACTED] [REDACTED] and muscle weakness. According to the 05/16/16 Minimum Data Set assessment, the resident was assessed as seldom understood with severe cognitive impairment, and required two person total assistance for bed mobility, transfers, dressing, and toileting. Resident #156 was further assessed to be at risk for developing pressure</p>	F 309		

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F 309	<p>Continued From page 33</p> <p>ulcers.</p> <p>When asked in an interview on 06/01/16 at 1:13 p.m. if Resident #156 had one or more pressure ulcers, Staff Q responded, "No" then indicated that the resident had multiple [REDACTED] to the [REDACTED] that were a result of [REDACTED].</p> <p>Review of a progress note dated 05/01/16 at 1:36 p.m. revealed staff documented, "...providing pericare, [REDACTED] abrasion noted, cleansed with soap and water and [REDACTED] ointment applied." On 05/01/16 at 8:43 p.m. staff noted, "Cleansed [REDACTED] with soap and water followed by [REDACTED] cream x2 this PM shift r/t (related to) abrasion to [REDACTED]. Repositioned Q (every) 2hrs (hours) and PRN (as needed)." A progress note on 05/06/16 at 9:07 p.m. revealed, "Resident continues with blisters on bilateral [REDACTED] midline area. Repositioned q2hrs. Applied [REDACTED] cream per order."</p> <p>The initial progress note(s) on 05/01/16 identified abrasions to the [REDACTED] while the 05/06/16 note identified, "blisters on bilateral [REDACTED] midline area." No assessments for the above identified skin issues were documented e.g. measurements, drainage/exudate, wound bed, peri-wound, signs or symptoms (s/sx) of infection or underlying etiology. Further, no non-pressure skin flowsheet was initiated as indicated in the policy.</p> <p>Review of the 05/09/16 "Weekly Skin Check" revealed nursing staff documented that skin was intact. None of the above identified skin issues were reflected on the skin check.</p>	F 309			

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F 309	<p>Continued From page 34</p> <p>Review of a progress note dated 05/10/16 at 2:59 p.m. revealed staff documented "...abrasion to midline buttocks with treatment in progress." On 05/11/16 at 9:19 p.m. staff documented "... continues with blister on [REDACTED] toward the midline area." In a progress note on 05/12/16 at 6:36 a.m. staff identified, "Resident has more blisters in the inner [REDACTED] ruptured,Resident has a diagnosis of [REDACTED] and is on [REDACTED] no blisters have been noted on other parts of the body."</p> <p>The facility had no documentation that the above wounds were assessed and monitored, no measurements were obtained, no description of wound bed, drainage, presence or absence of s/sx of infection, or peri-wound description. The 05/12/16 note stated three additional blisters were present in the inner [REDACTED]. Due to the lack of assessment and monitoring it is unclear how many blisters and abrasions the resident had. Further, there was no assessment as to whether the previously identified areas were improving or declining.</p> <p>Review of the 05/16/16 "Weekly Skin Check" revealed that nursing staff documented skin intact. The above documented skin issues were not identified on the skin check.</p> <p>On 06/07/16 at 9:18 a.m. Staff Q was interviewed related to the monitoring of Resident #157's blisters/abrasions to the [REDACTED]. When asked where to locate the non-pressure skin flowsheets, Staff Q responded "to be honest I haven't done skin checks on him since I started in March." When asked who would have the skin flowsheets he stated, "You would have to ask Staff B (DNS), he does the weekly skin rounds."</p>	F 309		

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F 309	Continued From page 35 On 06/07/16 at 9:42 a.m. when asked if there was any documentation on the identified abrasions and blisters to Resident #157's [REDACTED] Staff B stated, "No, I was unaware of the new condition" and further stated that skin conditions were usually reported to him directly or through the twenty-four hour report. Staff B indicated he should have been notified of the blisters. When asked how staff were to know if the wound(s) increased in size and depth and to notify the physician (as the policy directed) if no measurements were ever obtained, no response was given. Staff B did confirm that the facility "Skin Integrity Maintenance And Healing" Policy stated that non-pressure skin flowsheets need to be completed for monitoring and that these flowsheets were not initiated for this resident. The facility's failure to assess and monitor identified skin issues prevented staff from accurately identifying whether wounds were improving or deteriorating, responding to current treatment, or if areas had resolved and if new ones had developed.	F 309			
F 312 SS=E	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:	F 312		7/20/16	

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F 312	<p>Continued From page 36</p> <p>Based on observation, interview and record review it was determined the facility failed to ensure four (#s 88, 2, 34 & 177) of four dependent residents reviewed for Activities of Daily Living (ADLs) and two (#s 211 & 213) supplemental residents received necessary oral and/or nail care. These failures placed residents at risk for poor oral status, injury and embarrassment.</p> <p>Findings include:</p> <p>According to the facility's Oral Care Policy revised on 04/2011, the purpose of oral care was to: "cleanse and refresh the resident, prevent infection and dental caries, promote self esteem and comfort, cleanse and irrigate tooth surfaces, stimulate gums and mucosa." Oral care was to be done by staff as part of routine morning and bedtime care done by Nursing Assistants.</p> <p>RESIDENT #88 Resident #88 admitted to the facility in [REDACTED] 10 and according to the 03/03/16 Minimum Data Set (MDS) assessment had diagnoses to include Alzheimer's disease and dementia. According to this MDS, the resident required one person extensive assistance for bed mobility, transfers and personal hygiene. This MDS reflected the resident demonstrated no behaviors and no rejection of care.</p> <p>According to the 03/05/16 Care Plan (CP) labeled, "At risk for Oral/Dental health due to the following risk factors: Has upper and lower natural teeth with partial. Refuses for upper partial to be removed and cleaned, and if once removed will not allow to be reapplied. Refusal of dental checkups." Interventions included,</p>	F 312		

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F 312	<p>Continued From page 37</p> <p>"Encourage resident to allow you to brush natural teeth with soft toothbrush 1 to 2 times a day" and "Encourage resident to assist her with rinsing mouth with mouth wash 1x a day."</p> <p>Observation on 06/02/16 at 8:46 a.m. revealed the resident had heavy white debris in the gumline, which was receded. In an interview at that time, the resident discussed her breakfast, which she was not interested in eating.</p> <p>Observation on 06/03/16 at 12:07 p.m. revealed the resident lying in bed waiting for lunch. Two dry toothbrushes and a small tube of toothpaste were noted in a sealed plastic bag in a kidney basin at the sink. The top of the bag was folded under the contents and a folded paper towel and a tube of lipstick were noted on top of the bag. No mouthwash was noted. Observation at 12:41 p.m. revealed the resident sleeping with the lunch tray on the overbed table in front of her. The position and condition of the oral care equipment was unchanged. Observation at 1:53 p.m. revealed the oral care equipment remained in the same unused condition.</p> <p>Observation on 06/06/16 at 7:28 a.m. revealed the resident sitting up in a w/c (wheelchair) drinking a cup of tan liquid. Two dry toothbrushes and a small tube of toothpaste were observed in the plastic bag. The top of the bag was folded under the contents of the bag and in a kidney basin. The lipstick and folded paper towel appeared unmoved since 06/03/16.</p> <p>Observation on 06/06/16 at 9:17 a.m. revealed the resident sitting in a w/c in front of the nurse's station. The resident was smiling and talked about the chocolate ice cream she had just been</p>	F 312			

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F 312	<p>Continued From page 38</p> <p>given. The resident was noted with heavy white debris in gumline. Observation at 10:30 a.m. revealed the resident in her room looking at a year book. The resident was again noted with heavy white debris in the gumline. The toothbrushes by the sink remained dry, the lipstick and paper towel were unmoved.</p> <p>Observation on 06/06/16 at 11:01 a.m. revealed the resident in her room, looking at photos. The resident continued to demonstrate copious oral debris in the gumline. Now noted by the sink was a white lidded denture cup containing a set of partials. The lipstick on top of the oral care equipment was dislodged and now at the bottom of the kidney basin, but the toothbrushes were both dry and no mouthwash was noted. Similar observations of the resident's oral status and oral care equipment were noted at 11:26 a.m. and 1:16 p.m.</p> <p>Observation on 06/07/16 at 8:11 a.m. revealed the resident sleeping. The resident's oral care equipment remained by the sink, the toothbrushes remained dry in the plastic bag and the partial denture remained in the white denture cup. Similar observations were noted at 8:37 a.m. At 8:47 a.m., a Certified Nursing Assistant (CNA) delivered the resident's breakfast tray but was unable to rouse the resident. Observations on 06/07/16 at 10:37 a.m. revealed the resident lying in bed sleeping. The partial denture was still located in the white denture cup by the sink and the oral care equipment remained unmoved from previous observations. Similar findings were noted at 12:31 p.m.</p> <p>Observation on 06/07/16 at 1:05 p.m. with Staff Q confirmed the resident's toothbrushes in the</p>	F 312			

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F 312	<p>Continued From page 39</p> <p>sealed plastic bag were dry. The resident was sleepy at this time and not able to participate in an oral exam.</p> <p>Observation on 06/08/16 at 8:49 a.m. revealed the resident lying in bed sleeping with a cup of tan fluid held to her chest and the breakfast meal on the overbed table in front of her. Staff M was noted to attempt, unsuccessfully, to rouse the resident to eat.</p> <p>In an interview on 06/08/16 at 10:17 a.m., Staff R (Medical Records), upon reviewing CNA care documentation, confirmed there was no evidence of refusal of oral care from 06/01/16 through 06/07/16. Staff R indicated there was only one refusal for restorative during this period.</p> <p>In an interview on 06/08/16 at 11:52 a.m., Staff Q stated, "If she refuse we approach her, she likes family to come in and stuff like that, her brother, I know the family... it depends on her day, people in the afternoon can work with her better...". There was no indication in the record the resident had refused oral care in the previous week and no indication facility staff attempted any interventions to ensure Resident #88 received consistent oral care.</p> <p>A partial exam of the resident's oral cavity with Staff Q on 06/09/16 at 9:13 a.m. revealed the lower gumline caked with white debris and darkened areas on some of the teeth. Staff Q indicated it did not appear the resident's teeth had been cleaned.</p> <p>Additionally, according to the 12/03/15, 03/03/16 and 06/02/16 MDSs, facility staff identified the resident had "Broken or loosely fitting full or</p>	F 312			

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F 312	<p>Continued From page 40 partial dentures."</p> <p>According to a Care Area Assessment (CAA) dated 12/03/15, "This CAA triggered due to resident with loose upper partial dentures, causal and risk factors-resident is at risk for chewing/swallowing oral pain related to loose upper partial, dementia etc... resident has partial upper dentures and refuses to wear at most of the time... offer to see the dentist as resident has loose partial upper dentures, resident is being assisted with oral care when resident allows... proceed to care plan focusing on providing good oral hygiene and minimizing/preventing oral complications."</p> <p>In an interview on 06/08/16 at 11:54 a.m., when asked when Resident #88 last wore her partial, Staff Q replied "Yesterday, it would be for yesterday, I would have to ask." When asked to explain why staff would be directed to continue to implement what staff identified as ill fitting dentures Staff Q responded, "That's a good question, why would we offer one that doesn't fit?"</p> <p>In an interview 06/08/16 at 12:01 p.m., after reviewing the MDS, CAA and CP, when asked why staff would attempt to put a broken or loose fitting denture in a resident's mouth, Staff H (MDS Coordinator) replied, "That's a good question." Further interview and record review revealed no indication facility staff attempted to discern if the resident refused the use of the partials because they were "broken or loose."</p> <p>Failure to ensure Resident #88 consistently received the oral care she were assessed to require placed this resident at risk for declining</p>	F 312			

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F 312	<p>Continued From page 41</p> <p>oral status.</p> <p>RESIDENT #2 Resident #2 admitted to the facility in █ 13, and according to the 03/24/16 MDS had diagnoses of dementia and paralysis. The MDS indicated the resident was assessed to require extensive two person assistance for bed mobility and transfers and extensive one person assistance with personal hygiene. According to a 02/04/15 Nurse Aide's Information Sheet located in the resident's closet, the resident was "total care" for mouth care.</p> <p>According to the 03/16/16 "Self Care Deficit" CP, staff were directed to "Assist of 1 with maintaining personal hygiene and oral care every AM/PM shift and as needed." The 03/26/16 "At risk for Oral/Dental Health" CP, directed staff to "Brush natural teeth with soft tooth brush 1 to 2 times a day as resident allows. May be resistive to opening mouth. Attempt and encourage resident to allow oral care."</p> <p>Observation on 06/02/16 at 11:18 a.m. revealed the resident had heavy white debris in the front lower gumline.</p> <p>Observation on 06/03/16 at 1:50 p.m. revealed a kidney basin at the sink in the resident's room which contained three toothbrushes, two tubes of toothpaste, and one small bottle of mouthwash. In an interview at that time, the resident's roommate indicated the basin and oral care supplies located at the sink were his. No other oral care supplies were located at the sink or at the resident's bedside. Located in the resident's dresser drawer was an unopened bottle of mouthwash which retained its silver foil cover, located in a Ziploc</p>	F 312			

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F 312	<p>Continued From page 42</p> <p>bag. There were no toothettes (sponge tipped oral care devices) and no toothbrushes or toothpaste.</p> <p>Observation on 06/06/16 at 7:37 a.m. revealed the resident lying in bed on his back. While no observation of the resident's oral status was made at that time, there continued to be oral care equipment at the sink side for the roommate only, and no soft toothbrush as directed in Resident #2's CP. Resident #2's mouthwash continued to be sealed. Observation at 10:34 a.m. revealed the resident up in a wheelchair in his room watching television. The resident was noted at that time with white debris in the front lower gumline and what appeared to be receding gums. Similar observations were noted on 06/07/16 at 8:14 a.m. and 8:51 a.m.</p> <p>In an observation on 06/07/16 at 1:50 p.m. Staff X (Licensed Nurse) confirmed the only oral care equipment for Resident #2 was a bottle of (sealed) mouthwash located in the resident's dresser drawer.</p> <p>In an interview on 06/07/16 at 1:55 p.m., Staff W (CNA caring for this resident) confirmed there was no toothbrush or toothpaste available for this resident and reported she did not brush the resident's teeth with a toothbrush. Staff W stated, "I only wet the sponge (toothette) with water." When asked, Staff W was unable to demonstrate oral care for Resident #2 as he pushed her hand away. Staff W reported that she provided oral care for Resident #2 "Maybe two or three times a week." Observation at 1:50 p.m. on 06/07/16 revealed the resident continued to have moderate to heavy buildup of white debris in the gumline.</p>	F 312			

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F 312	<p>Continued From page 43</p> <p>However, review of the "Documentation Survey Report", revealed staff documented having provided personal hygiene, including brushing teeth, on both day and evening shift from 06/01 through 06/07/16.</p> <p>In a subsequent interview at 2:00 p.m., Staff X indicated that if CNA staff did not provide the care residents were assessed to require, it should be reported so Licensed Nursing staff could intervene. Failure to provide daily oral care as directed placed the resident at risk for mouth pain and decline in oral status.</p> <p>NAIL CARE According to the facility's 08/2014 policy on Nail care, "all residents on their bath day will have hand and foot nail cares done" and "all diabetic residents will have their Nail care done by Licensed Staff or DPM (Podiatrist). Any resident found to have long, thick, nails will be referred to the DPM." This policy specified "Nursing Assistants are to perform nail care as part of the bath except for Diabetic Residents." Staff were instructed, that "Nursing Assistants will report immediately to Licensed Staff any of the following: ...any nails so thick that they cannot be trimmed with standard nail clippers."</p> <p>RESIDENT #34 According to the 02/20/16 MDS, Resident #34 required extensive one person physical assistance with personal hygiene, including oral and nail care, and was completely dependent on staff for bathing. According to this MDS, the resident was not identified as diabetic.</p> <p>According to the 12/01/15 Nurse Aide's information sheet, located in the resident's closet,</p>	F 312		

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F 312	<p>Continued From page 44</p> <p>the resident required assistance with mouth care and was bathed on Tuesdays and Thursdays. According to the 01/13/16 "At risk for Oral/Dental Health due to ...Broken teeth, obvious or likely cavity...and inability to maintain oral hygiene due to cognitive impairment" CP, staff were directed to "brush natural teeth with soft tooth brush 2 to 3 times a day."</p> <p>Observation on 06/01/16 at 1:52 p.m. revealed Resident #34 had long fingernails, with nail polish noted on the distal third of the nail only. Brown debris was noted caked beneath the nails, predominately on the left hand. Copious white debris was noted in the resident's [REDACTED] front gumline, which was receded. Similar observations were noted on 06/03/16 at 8:47 a.m.</p> <p>Observation on 06/03/16 at 12:14 p.m. revealed Resident #34 in the dining room. The resident was noted to pull apart and eat a roll with her fingers. Observations at 1:43 p.m. revealed the resident lying in bed with heavy white debris in noted in the lower gumline. The resident's fingernails remained, long, unkempt and soiled.</p> <p>Observation 06/06/16 at 8:02 a.m. revealed a Ziploc bag in the top dresser drawer with oral care equipment. The bag was sealed and the tooth brushes within were dry (two of four were sealed in new containers). Observation at 8:07 a.m. revealed the resident in the dining room, not yet served breakfast. White debris was noted in the lower gumline and the resident's nails remained long, unkempt and soiled. Similar observations were noted at 10:32 a.m. and 11:38 a.m. The third and fourth fingers of the left hand had brown debris packed into the space from the tip of the finger to the tip of the elongated nails.</p>	F 312			

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F 312	<p>Continued From page 45</p> <p>Similar observations were noted at 1:32 p.m.</p> <p>Observation on 06/07/16 at 8:12 a.m. revealed the resident continued to have white debris in the lower gumline and soiled nails. The toothbrushes remained in the sealed Ziploc bag, dry and unused. Similar observations were noted at 10:49 a.m. and 1:25 p.m.</p> <p>During an observation on 06/07/16 at 1:25 p.m. Staff Q (Nurse Manager) confirmed the resident had long, soiled nails with polish only on the distal third of the nails. Staff Q examined the resident's mouth and confirmed heavy white debris in the lower front gumline, behind the lower front teeth and on/around a right lower back tooth. Staff Q indicated it did not appear the resident had received oral care. In an interview at that time, Staff S (Certified Nursing Assistant-CNA), indicated she had provided oral care with a swab (toothette) earlier in the day. Staff S indicated the resident was not cooperative with care, however Staff Q indicated he was not aware of any resident refusals.</p> <p>Record review revealed no indication the resident refused either oral or nail care from 06/01 through 06/07/16. In an interview on 06/08/16 at 9:46 a.m., Staff R (Medical Records) reviewed Resident #34's record and found no indication the resident had refusals. In an interview on 06/08/16 at 10:33 a.m., Staff S indicated there was no place to document refusal in the electronic record.</p> <p>Observation on 06/08/16 at 8:47 a.m. revealed the resident's fingernails were clean, but not trimmed. The resident indicated at that time she would be interested in a manicure.</p>	F 312			

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F 312	<p>Continued From page 46</p> <p>In an interview on 06/08/16 at 9:30 a.m., Staff Q stated, "We cleaned it (resident's nails) until she tolerated it...". Staff Q indicated, "The Activity (department) will do (trim and paint) the nails, I did an inservice. Bottom line is she is resistive and bottom line is we have to follow up...". Staff Q indicated that if the aides were not doing the required ADL care, for whatever reason, they need to let the nurse know so a team approach could be used (including the family) to meet the resident's care needs.</p> <p>RESIDENT # 211 Resident #211 admitted to the facility on [REDACTED] 16 with end of life care needs. According to the 05/31/16 MDS, the resident was dependent on two person physical assistance with personal hygiene and was diagnosed with diabetes.</p> <p>Observation on 06/03/16 at 12:05 p.m. revealed Resident #211 lying in bed. The resident was noted to have elongated toe nails, specifically the third and fourth toe on the [REDACTED] foot and the third and fourth toe on the right foot. Similar observations were noted on 06/06/16 at 11:42 a.m. and 1:21 p.m.</p> <p>In an interview on 06/07/16 at 12:52 p.m., Staff Q stated, "All of us on our floor (do nail care), the bath aides do the nail care, and the nurses take care of the people with diabetes that's part of the bath care." Staff Q elaborated most residents were bathed twice a week.</p> <p>During an observation on 06/07/16 at 12:58 p.m., Staff Q indicated that it was discussed that a podiatry referral could be made for Resident #211, but when pointed out the resident had</p>	F 312			

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F 312	<p>Continued From page 47</p> <p>multiple toe nails that were long and thin and could be trimmed he stated, "Yes I see that (elongated nails)." Staff Q indicated that whoever did the admission orders should identify the resident was a diabetic and direct licensed nursing staff to perform nail care rather than the CNAs.</p> <p>Observation on 06/08/16 at 8:54 a.m. revealed Resident #211's long, non fungal, toenails were trimmed. In an interview on 06/08/16 at 9:29 a.m., Staff Q confirmed there was no directions to Licensed Nurses to perform nail care for Resident #211, but that nail care for diabetics would be incorporated into the weekly skin check process.</p> <p>RESIDENT #177 According to the 04/13/16 MDS, Resident #177 admitted to the facility [REDACTED] 16. This MDS assessed the resident to require the assistance of one person for assistance with personal hygiene.</p> <p>According to the Care Plan dated 04/08/16, staff were directed to provide oral care using a soft tooth brush one to two times daily.</p> <p>Observation on 06/03/16 at 8:29 a.m. revealed the resident's gums and tongue appeared inflamed.</p> <p>In an interview on 06/08/16 at 9:06 a.m., Staff D stated the resident had a condition which caused lesion in her mouth and staff should provide oral care as needed. According to Staff D, Resident #177 directed her care and often refused assistance.</p> <p>Staff D was not able to provide evidence of the resident refusals of care nor was she able to</p>	F 312		

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F 312	<p>Continued From page 48</p> <p>provide evidence that oral care was provided as indicated on the CP or in Care Tracker (system used by the care giver to document care provided to residents).</p> <p>In an interview on 06/09/16 at 7:53 a.m., the resident stated she had two toothbrushes, one electric and one manual. The resident stated her gums may be swollen because the dentist had instructed her to brush her gums and maybe they got brushed "too hard".</p> <p>On 06/09/16 at 8:00 a.m., the resident informed Staff N that the staff hadn't brushed her teeth in over one week. The resident informed Staff N the care givers would often tell her they had an emergency and promise to return and provide oral care. According to the resident, staff rarely returned to provide her with oral care. Resident #177 stated she would like to have her teeth brushed at least once a day. She stated she also has requested dental floss.</p> <p>RESIDENT #213 Resident #213 admitted to the facility on [REDACTED] 16. According to the MDS dated 05/22/16, the resident had medical diagnoses of [REDACTED] and depression. During an observation on 06/01/16 at 12:15 p.m., Resident #213 was lying in bed with his feet exposed. The toenails on both feet were discolored and thick and long.</p> <p>A review of the skin assessment dated 05/30/16 revealed staff documented the resident had no problems with his toenails. A review of the skin assessment dated 06/06/16 revealed staff documented the resident's toenails were thick and [REDACTED] and indicated the resident</p>	F 312			

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F 312	Continued From page 49 should be referred to the in-house podiatrist. Observation of the resident's feet was made on 06/07/16 at 9:06 a.m. with Staff D. In an interview at that time, Staff D stated, "I probably could have cut a few of his toenails but some of them are thick and [REDACTED] and would have to be cut by the podiatrist." According to Staff D, the resident's toenails should have been clipped during his regularly scheduled bed bath. According to Staff D, the CNA should notify the licensed nurse if a resident had thick toenails that they were unable to trim. Staff D stated the resident would be referred to the in-house podiatrist for evaluation and treatment.	F 312			
F 329 SS=E	483.25(I) 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	F 329		7/20/16	

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F 329	<p>Continued From page 50</p> <p>drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure five (#s 56, 197, 34, 60 & 117) of five sampled and one (#177) supplemental resident reviewed were free of unnecessary medications. Failure to ensure: adequate indications for use; staff followed facility policy; and determine if behaviors were also potential adverse side effects, placed residents at risk to receive unnecessary medications.</p> <p>Findings include:</p> <p>RESIDENT #56 Resident #56 admitted to the facility [REDACTED] 16 with care needs related to dementia, kidney failure and other chronic illnesses. According to the initial Minimum Data Set (MDS) assessment dated 01/14/16, this resident was assessed to be "frequently incontinent" meaning she was incontinent of bladder seven or more times during a seven day assessment period, but was able to be continent when assisted with toileting at least once. An initial "Bowel and Bladder Assessment" completed by staff on 01/08/16 determined the resident to be "incontinent ." This assessment stated she did not require further assessment or a trial period of assisted toileting by staff to determine if her bladder continence could be</p>	F 329		

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F 329	<p>Continued From page 51</p> <p>improved. Staff then concluded the resident would use [REDACTED] briefs and would be checked for [REDACTED] by staff every two hours.</p> <p>Resident #56's care plan, initiated on 01/08/16, and revised on 05/27/16, identified her as [REDACTED].</p> <p>Review of initial Physician's Orders (PO), dated 01/08/16, revealed Resident #56 had been prescribed the medication "Vesicare", 10 milligrams (mg) at bedtime for [REDACTED] since admission.</p> <p>Review of monthly POs for February, March, April, May and June, 2016 revealed she continued to receive this medication each evening, during the past five months, ostensibly to promote improved [REDACTED] even though she was no longer being assisted with toileting by staff and was physically unable to toilet herself.</p> <p>Review of recent laboratory tests for Resident #56 found results of a test of her kidney's ability to filter fluids (GFR) on 02/25/16 which were abnormal and indicated impaired kidney function.</p> <p>While brief notes in her record found a monthly review by a consulting pharmacist, the notes did not address why the resident continued to need the Vesicare to help with [REDACTED] since she was no longer being toileted and was totally [REDACTED] according to staff documentation.</p> <p>On 06/08/16 at 11:45 am, the resident's continued daily use of Vesicare for [REDACTED] was discussed with the Nurse Manager (Staff G). He</p>	F 329		

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F 329	<p>Continued From page 52</p> <p>said Resident #56 had been toileted when she moved to the unit in early [REDACTED] but this was discontinued because she was asking staff for help with toileting every 30 to 60 minutes. Review of her record found no documentation of this care or concern.</p> <p>Review of a more recent Quarterly Assessment dated 04/014/16 did not identify any recent trial of toileting the resident. Staff G acknowledged Resident #56 was not toileted and was always incontinent, and said he would discuss the continued need for this medication with the resident's physician.</p> <p>RESIDENT #197 Resident #197 admitted to the facility on [REDACTED] 16 with care needs related to [REDACTED] colitis. The initial MDS, dated 02/18/16, identified this resident had a history of physically abusive and resistive behaviors towards staff. His care plan, dated 02/29/16, identified problems with mood and behavior disturbance and related goals of decreased behavioral symptoms. A 05/06/16 physician's note identified a goal of "Reducing agitation."</p> <p>On 06/08/16 at 12:50 a.m., Staff G was interviewed regarding the documented monitoring for behaviors and potential Adverse Side Effects (ASEs) of psychoactive medications which were administered to Resident #197 on both a daily and "as needed " basis.</p> <p>Review of Medication Administration Records (MARs) for April and May 2016 found staff had listed multiple potential ASEs to monitor, including agitation, restlessness, confusion. During the month of May 2016, staff consistently</p>	F 329			

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F 329	<p>Continued From page 53</p> <p>documented the resident showed evidence of none of these behaviors as potential or actual ASEs. However, on another page of the same MAR, staff documented frequent instances of yelling and resisting care by the resident, for instance on 26 of 31 days during May.</p> <p>Additionally, during May 2016, staff documented administering as needed doses of the anti-anxiety medication [REDACTED] for "agitation/ restlessness" on 14 of 31 days. While staff identified the behaviors as an indicator he needed additional medication, they did not identify or address the possibility that these behaviors were potential adverse side effects related to one or more of his prescribed medications, which required further assessment of his medications and their effects.</p> <p>On 06/08/16 at 12:50 p.m. interview with Staff G, the above inconsistencies with monitoring for behaviors and possible ASEs by Licensed Nursing staff was discussed. Documentation in the May 2016 MAR was reviewed, as well as the multiple instances when staff administered [REDACTED] for behaviors which were possible ASEs but were never identified as potential ASEs by staff who administered the medication. Staff G was unable to explain the inconsistencies.</p> <p>RESIDENT #34 Resident #34 admitted to the facility on [REDACTED] 15 and according to the 09/08/15 MDS, had multiple medical diagnoses including [REDACTED]</p> <p>Review of POs and MARs revealed Resident #34 had received the medication [REDACTED] 20 mgs (milligrams) daily for [REDACTED] since admission.</p>	F 329		

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F 329	<p>Continued From page 54</p> <p>According to the Nursing 2015 Drug Handbook located in the facility nurse's station as a reference, indications for the use of [REDACTED] for [REDACTED] were, "20 mg as a delayed release oral suspension, daily for 4 weeks, for patients who respond poorly to customary medical treatment, usually including an adequate course of H-2 receptor antagonist...".</p> <p>Record review revealed no indication staff documented the resident demonstrated symptoms associated with the diagnosis of [REDACTED] or considered continued need of use of this medication in the absence of symptoms.</p> <p>In an interview on the morning of 06/08/16, Staff Q (Nurse Manager) was asked for evidence staff considered Resident #34's continued need of [REDACTED] for the diagnosis of [REDACTED]. In an interview on 06/09/16 at 8:41 a.m., Staff Q stated, "I called the nurse practitioner yesterday and we discontinued it [REDACTED] because (the resident) shouldn't be on it for a long time...".</p> <p>Similar findings were identified for Resident #60 who, according to MARs and POs, had also received [REDACTED] for [REDACTED] daily since 09/02/15 with no assessment of continued need for use.</p> <p>RESIDENT #117 Resident #117 admitted to the facility on [REDACTED] 16 and according to the MDS dated 01/30/16, had medical diagnoses of [REDACTED]</p> <p>A review of the physician's order revealed the resident received [REDACTED] and</p>	F 329		

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F 329	<p>Continued From page 55</p> <p>██████████ all for the treatment of</p> <p>On 06/08/16 at 10:52 a.m., Staff D stated she was unclear why the resident received three different medications for ██████████</p> <p>In addition, the resident had an order for ██████████ capsules related to antibiotics use. According to Staff D, the resident completed the antibiotics on 05/06/16 and was unsure why the resident was still receiving Florastor. Staff D stated she would notify the resident's physician to inform him/her that the resident had completed the antibiotics and inquire if the medication should be discontinued.</p> <p>The facility's failure to monitor the resident's medications and indication for use placed the resident at risk to receive unnecessary medications.</p> <p>RESIDENT #177 Observation of medication pass on 06/07/16 at 8:54 a.m. revealed Staff N (Nurse Manager) administer pain medication to Resident #177 via a ██████████ - a ██████████</p> <p>The ██████████ was noted to have ██████████ with Staff N administering the medication to the ██████████ port.</p> <p>According to the September 2013 "Placement and Care of ██████████ policy, "unused catheters must be flushed... every 24 hours."</p> <p>Review of June 2016 MARs revealed direction to</p>	F 329		

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F 329	Continued From page 56 staff dated 04/07/16 "Flush... [REDACTED] line site daily...". In an interview on 06/07/16 at 9:51 a.m., Staff Y (Licensed Nurse) indicated both lines [REDACTED] were flushed every morning at 8:00 a.m. A 05/21/16 PO directed staff to administer pain medication every three hours (through the [REDACTED] port), rendering daily flushing of this port unnecessary, as it was already flushed eight times a day (during medication pass). In an interview on 06/07/16 at 10:13 a.m., Staff D (Nurse Manager) indicated when the resident originally admitted on [REDACTED] 16, there were no prescribed medications administered so both ports needed to be flushed. Staff D explained when the resident started to receive regularly scheduled medications, the port being used no longer required a daily flush stating, "They should have changed that out with the (new) order...". Administration of a daily flush when none was needed constituted the use of an unnecessary medication.	F 329			
F 425 SS=D	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	F 425		7/20/16	

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F 425	<p>Continued From page 57</p> <p>acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure pharmaceutical services which assured the accurate dispensing and administration of all drugs to meet the needs of each resident for seven (#s 211, 37, 88, 34, 28, 158 & 177) of 18 residents reviewed in Stage 2. Failure to clarify physician orders when required, follow orders as directed, ensure adequate indications and parameters for use and site rotation placed residents at risk for unnecessary medications, medication errors and unmet needs.</p> <p>Findings include:</p> <p>Refer to CFR 483.25(l)(1), Unnecessary Drugs, F-329</p> <p>RESIDENT #211 Record review revealed Resident #211 had a physician's order (PO) for Tylenol 1000 milligrams (mg) three times a day with directions it was not to exceed 3000 mg. Review of June 2016 Medication Administration Records (MARs) revealed the resident also had an as needed</p>	F 425			

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F 425	<p>Continued From page 58</p> <p>(PRN) order for Tylenol 640 mg every six hours as needed for pain/fever. According to the MAR, Resident #211 received the daily 3000 mg of regularly scheduled Tylenol, in addition to PRN Tylenol 640 mg for pain on 06/01/16, exceeding the physician ordered limit. Failure to ensure POs were clear and not conflicting caused the resident to receive medication outside PO parameters.</p> <p>RESIDENT #37 Observation of medication pass on 06/03/16 revealed Staff AA (Licensed Nurse-LN) prepare and administer multiple medications to Resident #37. According to POs, the resident was to receive [REDACTED] (International) Units", however, review of the house supply bottle from which Staff AA dispensed the medication, revealed the resident received [REDACTED] with 25 mg of Calcium.</p> <p>In an interview on the morning of 06/06/16, Staff M (LN) was unable to locate any [REDACTED] without calcium, and indicated the POs should be clarified to reflect the current house supply of Vitamin D-3 with 25 mg of Calcium.</p> <p>RESIDENT #88 Similar findings were identified for Resident #88 who received [REDACTED] with calcium when no calcium was ordered. Failure to ensure the order clearly reflected what staff administered placed residents at risk for medication errors.</p> <p>Review of POs revealed direction to staff to administer, "[REDACTED] der... every 24 hours as needed for constipation...". An additional order directed staff to administer, "[REDACTED] [REDACTED] as needed for No BM (Bowel Movement) in 2 days."</p>	F 425			

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F 425	<p>Continued From page 59</p> <p>Another order directed staff to administer, [REDACTED] Suppository... rectally as needed for no bowel movement in 8 hours after giving [REDACTED]</p> <p>Review of April 2016 MARs revealed facility staff administered [REDACTED] Suppositories on 04/09/16 and 04/18/16 without first administering the [REDACTED] or the [REDACTED] as directed by the physician. Additionally, nursing staff administered Sorbitol on 04/28/16 without first administering the [REDACTED] as ordered.</p> <p>RESIDENT #34</p> <p>Review of Resident #34's current POs directed staff to administer, [REDACTED] as needed for constipation if no results from [REDACTED] and [REDACTED] suppository...". The order was unclear as to when exactly the medication needed to be administered and record review revealed the resident didn't have an order for [REDACTED]</p> <p>Record review revealed Resident #34 had two different orders for a [REDACTED] suppository, one to be administered every 24 hours as needed for constipation, and one that should be administered for no BM in 2 days. In an interview at 11:56 a.m. on 06/08/16, Staff Q (Nurse Manager) indicated these orders needed to be clarified.</p> <p>Review of current MARs revealed a PO for [REDACTED] Tablet... as needed for constipation two time a day....". When asked in an interview at 11:28 a.m. on 06/08/16, when staff were expected to administer this medication, Staff Q indicated the order should be clarified to direct when staff should specifically administer this medication as it related to the other bowel medications (after how many hours of no BM).</p>	F 425			

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F 425	<p>Continued From page 60</p> <p>In addition, according to June 2016 MARs, staff were directed to administer " [REDACTED] [REDACTED] twice a day for Hypertension. Hold medication for systolic blood pressure less than 100 and/or heart rate less than 60." Record review revealed staff did not monitor the resident's blood pressure prior to the administration of this medication. In an interview at 11:54 a.m. on 06/08/16, Staff Q indicated the order would have to be clarified and staff directed to obtain the blood pressure prior to administering the medication, to enable staff to determine if the medication needed to be held.</p> <p>RESIDENT #28 Similar findings for Resident #28 current PO's revealed orders to give [REDACTED] 30 ml via [REDACTED] as needed for no BM in two days, then to administer a [REDACTED] suppository if no BM 8 hours after giving [REDACTED] and then a [REDACTED] was to be given if no results from [REDACTED] and [REDACTED]. If the resident did not have a BM within one hour of the [REDACTED] administration the MD was to be notified immediately.</p> <p>Additional bowel orders were noted directing staff to administer [REDACTED] every 24 hours as needed for constipation and to administer [REDACTED] every 24 hours as needed for constipation. There was indication as to when these medications were to be administered in relation to the other bowel medications.</p> <p>RESIDENT #158 Similar findings were identified for Resident #158 whose current POs were exactly the same as Resident #28's. Failure to ensure orders clearly directed staff when to administer medications placed residents at risk for medication errors and</p>	F 425			

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F 425	<p>Continued From page 61 unmet needs.</p> <p>RESIDENT #177 Record review revealed Resident #177 had a PO which directed staff to administer "[REDACTED]" (pain medication) 1 mg/ml (milligram per milliliter) every one hours as needed for Pain for Pain level 1-3, IV push...". A second order directed staff to "use 4 ml (milliliters) (of [REDACTED] for pain level 9-10...". Review of the MAR revealed staff administered 1 ml of [REDACTED] on 06/06/16 at 1:19 p.m. when the resident had a pain level of "10", contrary to instructions in the POs.</p> <p>In an interview on 06/07/16 at 9:40 a.m., Staff Y (LN who administered the 06/06/16 medication) indicated the resident had been out of the facility and missed the regularly scheduled 9:00 a.m. dose. Staff Y stated, "We gave the noon dose and then the same exact dose at one-something so it falls to the PRN medication... the pain level she said was 10." Staff Y was unable to explain why she administered one milliliter when the order directed four be administered for that pain level.</p> <p>Additionally, a PO dated 05/21/16 directed staff to administer Dilaudid "every three hours for pain" but the times staff were directed to administer the medications were: 12:00 a.m., 3:00 a.m., 6:00 a.m., 9:00 a.m., 12:00 p.m., 3:00 p.m., 6:00 p.m. and 10:00 p.m.</p> <p>When asked in an interview why the medications were not instructed to be given every three hours as the PO indicated, on 06/07/16 at 9:36 a.m., Staff N (Nurse Manager) stated, "She likes to direct her care." Failure to ensure clear physician orders placed the resident at risk to not receive</p>	F 425			

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F 425	Continued From page 62 intended pain coverage.	F 425		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the 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.	F 431		7/20/16

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F 431	<p>Continued From page 63</p> <p>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 properly labeled, secured and or discarded when expired. These failures placed residents at risk to receive medication not intended for their use and or medication that had expired.</p> <p>Findings include:</p> <p>MEDICATION ROOMS/CARTS FIRST FLOOR During initial tour of the facility on the morning of 06/01/16, review of the first floor medication cart revealed multiple house supply eye drops for multiple residents. Boxes of Artificial Tear eye drops were labeled with room numbers and not resident names. For example, boxes were noted with "115-1", "120-2", "122-2", and "118-2". Failure to ensure accurate labeling, including resident name, to facilitate safe administration of eye drops to the correct resident, placed resident's at risk for receiving contaminated eye drops.</p> <p>SECOND FLOOR On 06/01/16 at 8:29 a.m., observation of the second floor medication room with Staff C revealed a bottle a influenza vaccine in the refrigerator an open date of 02/03/16. A review of documentation provided by Staff C indicated the vaccine should be discarded 28 day after the open date.</p> <p>THIRD FLOOR Review of one of two of the third floor medication</p>	F 431			

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F 431	<p>Continued From page 64</p> <p>carts revealed similar findings for eye drops as what was identified on the first floor. Multiple boxes of Artificial Tear eye drops were labeled with resident room numbers rather than names. Additionally, a bottle of Combigan eye drops for Resident #3 was open and not dated. According to Staff BB (Licensed Nurse), the drops should be dated when open.</p> <p>MEDICATIONS AT BEDSIDE</p> <p>RESIDENT #34</p> <p>Observation on 06/06/16 at 1:32 p.m. revealed Resident #34 had medications at bedside. In a Ziploc bag in the resident's top drawer, along with barrier creams and lotion, were a bottle of Systane eye drops which expired 01/2016 and a box of Salonpas pain patches.</p> <p>During an observation on 06/07/16 at 1:25 p.m., Staff Q confirmed the presence of medications at bedside. Staff Q indicated he was previously unaware of the medications in the resident's possession and indicated the resident should not store medications at the bedside. Staff Q stated, "We are required to keep it (medications) with us", as he removed the medications from the resident's room. The facility failed to ensure all medications were stored in a locked storage area with access limited to authorized staff.</p> <p>RESIDENT #177</p> <p>Observation on 06/01/16 at 8:45 a.m. revealed Resident #177 had a bottle of magnesium on a dresser in her room. During an observation on 06/06/16 at 10:09 a.m., a bottle of magnesium was observed on the resident's night stand next to her bed. Observation on 06/09/16 at 7:54 a.m. revealed a bottle of magnesium liquid on the resident's night stand next to her bed.</p>	F 431			

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F 431	Continued From page 65	F 431			
F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted</p>	F 441		7/20/16	

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F 441	<p>Continued From page 66 professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure staff completed handwashing when indicated during resident care. During two observations of incontinence care for Resident #56, staff failed to complete handwashing after pericare and before touching the resident or objects in the room. Failure to complete handwashing when required created the potential for transmission of infectious organisms.</p> <p>Findings include:</p> <p>Resident #56 admitted to the facility [REDACTED]/16 with care needs related to dementia, impaired mobility, and other medical conditions. The most recent Minimum Data Set (MDS), dated 04/14/16, revealed she required extensive assistance from staff for transfers and toileting. The current care plan, dated 05/25/16, stated Resident #56 was to be checked for incontinence every 2 to 3 hours and as needed, and provided incontinence care by staff.</p> <p>On 06/06/16 at 9:23 a.m., a Nursing Assistant (NAC-Staff J) entered the resident's room and told Resident #56 she would provide incontinence care and change her brief. Staff J washed her</p>	F 441			

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F 441	<p>Continued From page 67</p> <p>hands and put on clean gloves, then removed the resident's wet brief. She washed the resident then moved her from her back to her left side to wash her buttocks. After placing the soiled brief and the soiled gloves in a plastic bag, Staff J took new gloves from a pocket and donned these without first washing her hands or using a sanitizing gel.</p> <p>She then placed a clean brief on the resident and pulled up the resident's pants. She handed her the call light, lowered the bed and turned the TV on for the resident. She also handled the resident's glasses and her Bible before removing the gloves and washing her hands.</p> <p>At 9:40 a.m. on 06/06/16, Staff J was interviewed about her training regarding when to wash her hands. Staff J said she was trained to wash hands after entering a resident's room and before leaving the room. When asked if there were other times during incontinence care when she needed to wash her hands, she paused, then said "When I go in and when I leave." When asked specifically if she had been trained to remove her gloves and wash hands after washing the resident's perineal area, she said she did wash hands before she left the room. She acknowledged she regloved after cleaning the perineal area but didn't wash hands before donning clean gloves.</p> <p>On 06/07/16 at 9:25 am, another NAC (Staff K) was overheard asking Resident #56 if she wanted to lie down in bed. The resident replied, "Yes- I'm wet." Staff K helped the resident transfer into the bed. Staff K pulled the privacy curtain and was wearing gloves as she removed the resident's pants and incontinence brief. She washed the resident using disposable wipes, then turned her</p>	F 441		

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F 441	<p>Continued From page 68</p> <p>to her [redacted] side to wash her buttocks.</p> <p>At 9:32 a.m., Staff K did not remove the gloves soiled during pericare or wash her hands. Staff K placed a clean brief under this resident, touching the resident's hip and pants several times, as well as the bed sheet, the bed control and the edge of the privacy curtain. After this, Staff K removed the soiled gloves, but did not wash her hands. She put on another pair of gloves and placed the soiled brief and used wipes in a bag, which would again contaminate the gloves. She then touched the resident's bed linen and the bed control as she lowered the head of the bed.</p> <p>At 9:45 a.m. on 06/07/16, Staff K was asked about her training regarding handwashing during resident care. She said was told to wash her hands when entering a room and before leaving. When the issues observed from not removing soiled gloves or washing hands after pericare were reviewed, she did not reply. When a more specific explanation was provided, Staff K commented, "I did wash my hands, after I lowered her bed."</p> <p>On 06/07/16 at 9:50 a.m. the Registered Nurse (Staff L) assigned to this resident was asked about the facility's policy/ procedure for handwashing by staff during incontinence care. Staff L acknowledged staff were to remove gloves and wash their hands after completing a soiled task (such as incontinence care) before completing clean tasks (such as dressing and positioning a resident or touching items in the room).</p> <p>On 06/08/16 at 11:30 a.m., the above observations were reviewed with the Nurse</p>	F 441			

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F 441	Continued From page 69 Manager (Staff G). The above observations regarding the lack of hand washing by staff after washing the resident's perineal area and the facility's infection control procedures were discussed. Responses by both staff stating they were trained to wash hands after entering and before leaving a resident's room but not between soiled/ clean tasks during pericare were also reviewed. Staff G stated the current procedures would be reviewed with all staff to address current infection control practices.	F 441			
F 518 SS=D	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure four (Staff CC, DD, EE & FF) of five staff interviewed were knowledgeable about procedures for emergent situations which could occur in the facility. Failure to ensure staff knew what to do in the event of an earthquake, an armed intruder, a missing person and/or knew how to use a fire extinguisher, placed residents at risk of harm in the event of an emergency. Findings include: In an interview on 06/08/16 at 9:55 a.m., Staff	F 518		7/20/16	

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F 518	<p>Continued From page 70</p> <p>CC, Laundry Services, declined to be interviewed. She stated she could not speak English very well and walked away.</p> <p>In an interview on 06/08/16 at 10:00 a.m., Staff FF, Receptionist, stated she had little experience in using a fire extinguisher. When asked if she could use a fire extinguisher to put out flames, she replied, "Yeah, kinda. I would probably get help." Staff FF did not know the acronym for Pull, Aim, Squeeze and Sweep, (PASS). Staff indicated she would page "Code Blue" to alert for a missing resident and/or an earthquake.</p> <p>In an interview on 06/08/16 at 10:51 a.m., Staff EE, HR/Staff Coordinator, stated that she had never held or used a fire extinguisher. When asked if she knew how to use one, Staff EE stated, "I don't know." Staff EE also did not know which code to call for a missing resident. Staff EE said that staff have all this information on the back of their identification badges. She said hers did not have this information.</p> <p>In an interview on 06/08/16 at 10:51 a.m., Staff DD, Dietary Aide, stated that she preferred to answer questions in Spanish, her first language. In Spanish, when asked what she would do if she noticed a fire in a resident's room, Staff DD said, "We help the nurse... I can't answer". When asked how to use to fire extinguisher, Staff DD said, "We have to spray. I can't answer that question. Spray. They showed me but it was many years ago." In response to a missing resident, Staff DD stated, "The alarms are activated. The nurses are in charge since we are in the kitchen. That hasn't happened here." Staff DD stated she would not know how to react if confronted by an armed intruder. When asked</p>	F 518			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/09/2016
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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 518	<p>Continued From page 71</p> <p>how she would respond during an earthquake, Staff DD stated, "I don't know how to answer that question. They train us but the reality is... I would get under a table or piece of furniture."</p> <p>In an interview on 06/08/16 at 9:40 a.m. Staff I, Maintenance Director, stated, "We have disaster manuals in every charting room."</p> <p>In an interview on 06/08/16 at 1:10 p.m., Staff C, Staff Development Coordinator, stated that two of the identified staff had not been trained in emergency preparedness procedures. She indicated Staff CC was hired on 02/03/16 and there was no proof of training documented. Staff C indicated Staff FF was hired on 02/26/16 and there was no proof of training documented. Staff C stated the two staff were scheduled to complete training in June 2016. When asked to produce a training schedule, Staff CC acknowledged the training was not on the June and July calendar in her computer.</p> <p>Failure to ensure the frontline staff were familiar with the facility disaster manual procedures, and knew what to do if an emergency arose in the facility, placed residents, who were reliant on staff assistance, at risk for an unsafe environment.</p>	F 518			