

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

PRINTED: 11/07/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505483</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/06/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ALASKA GARDENS HEALTH AND REHABILITATION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6220 SOUTH ALASKA STREET TACOMA, WA 98408</b>
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Alaska Gardens Health and Rehabilitation Center on 7/23/13, 7/24/13, 7/25/13, 7/26/13, 7/29/13, 7/30/13, 7/31/13, 8/1/13, 8/2/13, 8/5/13 and 8/6/13. A sample of 46 residents was selected from a census of 114. The sample included 33 current residents and the closed records of 13 discharged residents.</p> <p>The survey was conducted by:</p> <p>  RN, MN   RN, BSN, MSN   RN, BSN   RN, BSN   RN, BSN   RD, MS, CD                 </p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging and Long Term Services Administration Residential Care Services, District 3, Unit B P.O. Box 45819 MS: N27-24 Olympia, Washington, 98504-5819</p> <p>Telephone: (253) 983-3800 Fax: (253) 589-7240</p> <p><i>[Handwritten Signature]</i> Signature _____ Date _____</p>	F 000	<p><b>IDR AMENDED</b></p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241 SS=D	<p><b>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</b></p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to promote a dignified dining experience for 3 of 23 Sample Residents (#s 20, 48 &amp; 199) who required assistance with eating of the 46 residents who were included in the Stage 2 review. This failure violated the residents right to dignity.</p> <p>Findings Include:</p> <p><b>RESIDENT #20</b></p> <p>Resident #20 was admitted to facility with multiple diagnoses which included memory loss. Annual Minimal Data Set (MDS) dated 7/4/13 revealed Resident #20 required staff assistance with eating.</p> <p>On 7/29/13 at 5:32 p.m., Staff QQ and Staff C were addressing Resident #20 as "feeder" and not by resident's legal name. Both staff addressed the resident as a "feeder" during the evening meal in the dining room with other residents present.</p> <p>In an interview with Staff F on 07/29/13 at 5:35 p.m., Staff QQ acknowledged that she addressed resident by calling her "feeder" and not by</p>	F 241	<p style="text-align: right;"><b>IDR AMENDED</b></p>	
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F 241	<p>Continued From page 2 resident's legal name.</p> <p>By failing to address Resident #20 by her name instead a label of "feeder" placed the resident at risk of not being recognized as a unique individual.</p> <p><b>RESIDENT #199</b> Resident #199 admitted to facility on [REDACTED]/13. Admission Minimal Data Set (MDS) dated 3/9/13 revealed the resident as cognitively impaired and required staff assistance with eating.</p> <p>On 7/29/13 at 5:45 p.m., Staff GG was observed standing while assisting Resident #199 to eat.</p> <p>In an interview with Staff GG on 7/29/13 at 5:50 p.m., asked Staff GG if standing while feeding was facility expectation. Staff GG stated "I know the expectation is to sit while assisting the resident to eat, but I stand while feeding because I am short." Staff F also stated that it is easy for her to feed the residents while standing up.</p> <p>Standing while feeding the resident diminishes the quality of dining experience and fails to treat the resident in a dignified manner.</p> <p><b>RESIDENT #48:</b></p> <p>Observation on 7/29/13 at 5:45 p.m. in the Cascade Dining Room (DR) revealed Staff EE stood up next to Resident #48, who was seated, to provide maximum assistance with eating the dinner meal. Resident #48 was nonverbal during the meal. During interview, Staff EE stated she did not think Resident #48 had any preference whether she stood while assisting her to eat.</p>	F 241	<p style="text-align: center;"><b>IDR AMENDED</b></p>	
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F 250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to provide medically related social services for behavior management or communication difficulties for 2 of 4 Sample Residents (#s 17 &amp; 200) reviewed for either behavior management or difficulty with communication of the 46 residents who were included in the Stage 2 review. This failure placed Resident #17 and Resident #200 at potential risk for not having their individual needs met.</p> <p>Findings Include:</p> <p>RESIDENT #17 On 8/1/13 at 4:10 p.m. Staff G stated Social Services were responsible for behavior, cognition, mood and discharge of residents.</p> <p>Resident #17 was admitted on [REDACTED] 12 with diagnoses to include [REDACTED] with [REDACTED] history, [REDACTED] and [REDACTED]. The resident had a recent diagnosis of [REDACTED]. Staff G stated the resident had experienced a recent family loss and had no</p>	F 250	<p style="text-align: center;"><b>IDR AMENDED</b></p>	

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F 250	<p>Continued From page 4</p> <p>reliable support system until a guardian was appointed in April 2013.</p> <p>Resident #17's current [REDACTED] Care Plan dated 6/28/13 identified the resident had problems/concerns of [REDACTED] verbal behaviors symptoms directed toward others, and non-compliance with orders not eat or drink anything by mouth (NPO). The goals identified were for the resident to have no injuries to self or others every day for 90 days. The Approach/Intervention included in part directions for staff to approach the resident calmly and speak in calm voice, attempt to refocus behavior, encourage in problem solving, chart intervention success/failure, explain risk versus benefits of care, and notify the provider.</p> <p>The July 2013 Behavior Monitoring Flow Sheet identified staff responses to resident behaviors related to [REDACTED] and insomnia. The target behaviors were identified as: 1) yelling out, 2) sleeplessness, 3) crying, 4) cursing, 5) [REDACTED] 6) placing [REDACTED]. The interventions for these behaviors were listed as: 1) reassurance and reminders, 2) 1:1 activities and social services. The medications listed to be given to the resident for these behaviors were [REDACTED] and [REDACTED].</p> <p>The Interdisciplinary Progress Note (IPN) dated 6/23/13-7/29/13 documented 17 entries of resident crying, yelling and or cursing, sometimes loudly, when food was taken away because of</p>	F 250	<p style="text-align: center;">IDR AMENDED</p>	
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F 250	<p>Continued From page 5 non-compliance with NPO.</p> <p>Review of Interdisciplinary Progress Noted (IPN) between 6/13/13 through 8/1/13 documented 25 episodes of Resident #17 wandering the hallways of facility during evenings and nights looking for food, eating from the garbage and the soiled food waste cart, hiding food in his room, taking food from the residents fridge, asking other residents for food, buying food from the vending machines, and drinking large volumes of sodas leading to increased gastric output and skin breakdown.</p> <p>Review of IPN notes between 5/13/13 through 8/31/13 documented the resident turned off his/her [REDACTED] stopping the [REDACTED] 18 times. The resident's body weight loss during this three month period of 5/3/13 to 8/1/13 was 19 pounds, a severe unplanned weight loss, indicating interventions were not achieving the intended goal of no injury to self.</p> <p>IPN notes dated 6/20/13 documented the Resident #17 had feces in his/her hair and feces on the walls in his/her room. During shower staff noted object sticking from lower body orifice. Resident had been observed with object earlier in the day and talked to by staff.</p> <p>On 7/4/13 progress notes documented a CNA found a package of plant food and packages of mayonnaise on resident's bedside table. The progress note documented the CNA explained to Resident #17 that plant food was poisonous and</p>	F 250	<p style="text-align: center;">IDR AMENDED</p>	
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F 250	<p>Continued From page 6 reminded the resident she/he was still NPO.</p> <p>On 7/30/13 at 11:15 am Staff B stated she/he had no safety concerns related to Resident #17.</p> <p>On 7/24/13 during Stage 1 survey, surveyor and Staff E when checking Resident #17's call light found a carton of milk and a hamburger in the top drawer of the resident's bedside table when the resident was to be NPO.</p> <p>In response to these behaviors, crying, yelling/screaming and cursing, the resident was documented to have been given [REDACTED] and/or [REDACTED] 21 times between 6/14/13 and 8/1/13.</p> <p>On 5/20/13, during an outburst on the evening shift, it was documented Resident #17 stated he/she was bored and unhappy and began crying.</p> <p>On 6/1/13 it was documented the resident had episode of crying yelling and cursing, saying the resident wanted to go to hospital, related to being bored, [REDACTED] was given.</p> <p>On 6/7/13 Resident #17 was placed on alert for harm following an episode of agitation document on 6/4/13 in the NAC Care Directives PRN notes and the IPN notes by nursing staff at 2315 (11:16 p.m.). The notes reported Resident #17 was agitated stated wanting to go home, cursing repeatedly, saying feeling as though (hurt</p>	F 250	<p><b>IDR AMENDED</b></p>	
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F 250	<p>Continued From page 7</p> <p>because) he has no home. Episode continued until 6/5/13 at 5:00 am when resident was documented to be calm but awake. During this time the resident was given [REDACTED] and [REDACTED]</p> <p>Review of Social Services Progress Notes documented Staff I meeting with resident following episodes on 5/20/13 and 6/13/13. On 5/21 Staff I asked the resident if something had upset him and if he wanted something. On 6/13 Staff I explained risks and benefits of drinking soda and resident reluctantly gave up with understanding the soda would be put in the cabinet for another time. On 7/29/13 Staff I stated she/he felt had established a rapport with the resident who had come that morning to ask for the Nintendo game she/he had thrown in the garbage several days before. Care conferences were held with the resident and guardian on 5/31/13 and 6/27/13 to discuss risks and benefits of turning off the TPN and the resident's non-compliance with NPO.</p> <p>An undated Behavior and Evaluation and Review /Consent completed by Staff G describes Resident #17 as having complex medical conditions and issues. On 7/30/13 at 09:14 am, Staff PP stated the resident was extremely heavy care, more than the other residents on the hallway. On 7/30 at 3:41 p.m., Staff B stated the facility has a limit to addressing Resident # 17 quality of life and not violate his/her rights.</p> <p>Resident #17 had multiple episodes of documented behaviors. Although interventions</p>	F 250	<p style="text-align: center;">IDR AMENDED</p>	
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F 250	<p>Continued From page 8</p> <p>were implemented to address the Resident #17's behaviors, the resident's behaviors continued and the resident's health status declined, the facility failed to reassess Resident #17 to determine what was the root causes of the resident's continued behaviors. By failing to reassessing the resident to determine the root causes of his/her continued behaviors, the facility did not revise the resident's plan of care to meet the resident's individual psychosocial needs in an attempt to decrease these behaviors and improve the resident's quality of life.</p> <p><b>RESIDENT #200</b> Resident #200 was admitted to the facility on [REDACTED] 13. [REDACTED] the resident's primary language for communication.</p> <p>Record review of the admission Minimum Data Set (MDS, an assessment tool) dated 7/5/13 and a significant change MDS dated 8/1/13 both identified the resident had diagnoses of [REDACTED] muscle weakness and difficulty walking. Both MDS assessments also revealed Resident #200's speech was unclear (slurred or mumbled), was usually understood, usually understood others and had adequate vision and hearing.</p> <p>On 7/24/13 at 9:20 a.m. Staff C reported Resident #200 experienced a fall that resulted in a hip fracture on 7/14/13. The resident went to the hospital for surgery and returned to the facility [REDACTED] 13.</p>	F 250	<p style="text-align: center;"><b>RE AMENDED</b></p>	
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F 250	<p>Continued From page 9</p> <p>On 7/29/13 at 3:55 p.m. when asked about the fall, Resident #200 was unable to answer questions due to a language barrier. The resident was unable to answer questions using simple English language and terms.</p> <p>Interviews with multiple staff revealed conflicting statements regarding Resident #200's ability to understand and communicate in English or how staff communicated with him/her.</p> <p>On 7/29/13 at 4:00 p.m. Staff AA was asked how staff normally communicated with Resident #200. Staff AA indicated that since this resident returned from the hospital after surgery, she/he had been more difficult to communicate with. Staff AA then stated that the resident had a communication board staff used. At this time, the surveyor went to the resident's room with Staff AA to locate the communication board. Staff AA was unable to locate the communication board and stated "Things get misplaced sometimes."</p> <p>On 7/30/13 at 8:35 a.m. Staff F assisted to interpret conversation with the resident. During this interview, Resident #200 was able to describe in her/his native language the events of the fall without any difficulty. Per the interpreter, the resident also described feelings of being scared indicating the resident was afraid of falling</p>	F 250	<p style="text-align: right;"><b>IDR AMENDED</b></p>	
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F 250	<p>Continued From page 10</p> <p>again. Resident #200 went on to state "I feel like they could do something else because I was nervous. Now that I think about it I want to cry because I felt lonely." Resident #200 was observed at this time with tears in her/his eyes.</p> <p>On 7/30/13 at 9:38 a.m. Staff Y stated that when communicating with Resident #200 simple words were used.</p> <p>On 7/30/13 at 1:32 p.m. Staff C was asked how staff communicated with Resident #200. Staff C indicated asking mostly "yes" and "no" questions to this resident. Staff C also indicated that prior to going to the hospital this resident was easier to communicate with, however, the resident was still able to get needs addressed with simple terms and without the use of her/his native language most of the time. When asked about a communication board Staff C replied that one was not made for this resident and stated "If I couldn't communicate with her/him I would have made one."</p> <p>On 7/31/13 at 1:25 p.m. Social Service Staff H was asked how staff determined if communication with a resident that spoke another language was effective. Staff H stated the process for Resident #200 started with getting some history information. Staff H added that the resident understood and spoke some English. Staff H also added that Resident #200's cognition was better prior to going to the hospital before the</p>	F 250	<p style="text-align: right;"><b>IDR AMENDED</b></p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505483</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/06/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALASKA GARDENS HEALTH AND REHABILITATION</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>6220 SOUTH ALASKA STREET TACOMA, WA 98408</b>		
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F 250	<p>Continued From page 11 fall 7/14/13.</p> <p>A Fall Risk care Plan originally dated 7/11/13 directed staff to "Remind Resident frequently to use the call light for assistance." This care plan also identified that this resident was a fall risk related to cognition.</p> <p>A Communication Care Plan originally dated 7/5/13 did not include approaches for staff to use to ensure Resident #200 could understand instructions given, such as, how to use the call light.</p> <p>Record review revealed Resident #200 had another fall on 7/29/13. On 8/1/13 at 2:07 p.m. Resident #200 was interviewed again with Staff F present to translate. The resident was asked about the most recent fall on 7/29/13. The resident explained that she/he slipped out of the wheelchair when trying to get up. The resident was not able to say if she/he knew how to call staff for assistance. The resident stated she/he knew what the call light was, but was not aware that it was used to get help from staff. An explanation of the call light was given to the resident who then stated "Oh wow I didn't know." The resident went on to state "I don't need anything right now but later when I go to bed...the other night I had to use the bathroom and I had to go in my bed." Approximately three minutes later the resident was asked how she/he would get staff assistance for something like using the</p>	F 250	<p style="text-align: right;"><b>IDR AMENDED</b></p>	

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F 250	<p>Continued From page 12</p> <p>restroom. The resident was unable to answer this question. Additionally, the resident expressed still having feelings of fear related to falling.</p> <p>On 7/31/13 at 1:25 p.m. Staff H reported he/she did not know Resident #200 felt "scared and lonely" after falling on 7/14/13.</p> <p>On 8/1/13 at 3:52 p.m. Staff AA indicated that she/he had not noticed Resident #200 use the call light and stated "Sometimes her/his roommate will push it for her/him."</p> <p>On 8/1/13 at 4:00 p.m. Staff W explained that to communicate with Resident #200 simple words were used. Staff W added she/he had not noticed Resident #200 using the call light and stated "It's usually the roommate that does it for her/him."</p> <p>On 8/2/13 at 8:55 a.m. Staff X stated that when communicating with Resident #200 "I just talk to her/him...she/he communicates back to me." Staff X added he/she had not noticed Resident #200 using the call light lately and stated "She/he rarely asks for things." Staff X was asked if there was a schedule in place of how often Resident #200 would be checked on. Staff X replied that there was not a schedule and stated "she'll/he'll let her/his needs known." Staff X stated if the resident needs to use the restroom "She/he just lets us know."</p>	F 250	<p style="text-align: center;"><b>IDR AMENDED</b></p>	
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F 250	<p>Continued From page 13</p> <p>A speech therapy note dated 8/5/13 documented Staff S stated Resident #200 "had cognitive communication deficits and will need constant supervision and multiple verbal cues to complete ADL's (Activities of Daily Living) safely." The therapy note identified Staff S used an interpreter during this assessment.</p> <p>Failure to identify to what extent communication and/or cognitive barriers impacted Resident #200's ability to understand staff; failure to identify resident ability to express needs and failure to identify specific effective communication approaches for staff to use prevented the resident from knowing how and when to summon staff which placed the resident at risk for injury and to not be able to obtain staff assistance when needed. Failure to implement an effective means of communication for the resident also prevented staff from being aware of unmet psychosocial needs which had the potential to adversely affect the resident's psycho-social well-being.</p>	F 250		
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</p>	F 279	<p style="text-align: center;"><b>DR AMENDED</b></p>	

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F 279	<p>Continued From page 14 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, record review and interview the facility failed to develop and/or revise comprehensive care plans that consistently included measurable objectives and timetables for 3 of 6 Sample Residents (#s 16, 17 &amp; 171) reviewed for care planning for behaviors and/or urinary incontinence of the 46 sampled resident included in the Stage 2 review. This failure to develop and/or revise Resident #s 16, 17 &amp; 171 care plans placed the residents at risk to not attain or maintain their highest practicable physical, mental and psychosocial well-being.</p> <p>Findings include:</p> <p>RESIDENT #17</p> <p>Resident #17's Minimal Data Set (MDS) quarterly</p>	F 279	<p style="text-align: right;"><b>IDR AMENDED</b></p>	
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F 279	<p>Continued From page 15</p> <p>assessment dated 6/30/13 lists the additional diagnosis of cognitive loss/dementia, psychosocial wellbeing, and behavioral symptoms not included in the MDS dated 12/10/12. The Behavior Monitoring Flow Sheet (BMFS) for July 2013 lists the diagnosis of [REDACTED] and insomnia. The target behaviors were hallucinations, cursing, yelling, smearing [REDACTED] and placing objects [REDACTED].</p> <p>The interventions were reminders and reassurance and 1:1 activities and social services. If the resident was not responsive to the initial interventions, the use of medication could be started.</p> <p>The Interdisciplinary Progress Note (IPN) documented the residents behaviors between 5/13/13 and 7/31/13 included turning off the IV pump - the only source of nutrition and hydration - removing the [REDACTED] several times a day, eating from the soiled food waste cart and garbage and non-compliance with NPO (nothing by mouth) status.</p> <p>The Behavioral Disturbance Care Plan date 6/28/13 includes non-compliance with NPO. The interventions include those listed on the BMFS. Between 6/13/13 and 8/1/13 25 there were 25 entries documented of the resident's non-compliance behavior with being NPO. The care plan however was not revisited for possible alternatives to the existing intervention.</p>	F 279			

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F 279	<p>Continued From page 16</p> <p>The Nutrition Hydration Care Plan was updated 7/24/13 to include the problem of the resident turning off the [REDACTED]. The interventions were not revised/updated to include a response to the resident turning off the IV pump.</p> <p>On 7/30/13 at 3:41 p.m. when asked regarding Resident #17's behaviors, Staff B stated the facility has a limit to addressing Resident #17 quality of life and not violate his/her rights.</p> <p>Refer to F 250 Social Services Refer to F 328 Treatment and Care of Special Needs</p> <p>RESIDENT # 16: Refer to F 282 for observations, interviews, and medical history. Resident #16 was re-admitted on [REDACTED] 13 to the facility after hospitalization at a local hospital. The hospital history and physical documented Resident #16 was treated for a urinary tract infection (UTI) versus [REDACTED] (infection in [REDACTED]).</p> <p>Minimum Data Set (MDS) dated 5/2/13 identified pertinent diagnoses for Resident #16's as [REDACTED].</p> <p>[REDACTED] In this MDS resident was identified as being an extensive assist for bed mobility, toilet use, personal hygiene, transfer, dressing and bathing. The MDS identifies the resident as being incontinent with bladder elimination. On the Care Area Assessment (CAA) dated 5/6/13 for Resident #16 it was documented the resident had urinary incontinence and a care plan should</p>	F 279	<p style="text-align: right;">IDR AMENDED</p>	
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F 279 Continued From page 17  
be generated for this indicator.  
On 7/26/13 at 1036 Staff B, after reviewing Resident #16's MDS CAA dated 5/6/13, confirmed that there was no care plan for urinary incontinence or urinary tract infections. Since re-admission on 4/25/13 Resident #16 had three falls and was treated congruently for UTI's. Not having a care plan in place for urinary incontinence and urinary tract infections when indicated by the comprehensive assessment (MDS) dated 5/2/13 placed the resident at potential risk for not being assessed to determine if the resident's frequent UTI's could have been a contributing factor to why Resident #16's falls.

F 279

**RESIDENT #171**

Resident #171 was admitted to facility [REDACTED] /13 with multiple diagnoses which included incontinence of urine. Admission MDS dated 03/26/13 reveal resident was assessed to be frequently incontinent of urine. This resident was also identified as having an increase in behavior symptoms ( [REDACTED] )  
MDS dated 6/10/13 reveal the resident was re-assessed to have had a decline in in urinary function to always being incontinent. Review of urinary incontinence care plan (CP) revealed care plan was last reviewed 5/30/13. This care plan did not include any interventions to address the resident 's decline in urinary function. as identified by the 6/10/13 MDS, the resident has had this change in incontinence for 43 days without the facility addressing the resident's needs in the care plan.  
In an interview with Staff B on 7/31/13 at 1:35

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F 279	<p>Continued From page 18</p> <p>p.m., Staff B acknowledged that elimination care plan had not been updated to address resident # 171's decline in urinary function and stated "the care plan should have been updated to address resident's change."</p> <p>Additionally Resident #171 MDS dated 5/31/13 revealed that resident exhibited behavior symptoms such as hallucinations, delusions and wandering. This MDS also revealed that these symptoms occurred about 1-3 days</p> <p>MDS dated 6/10/13 reveal that resident exhibited symptoms such as [REDACTED] and wondering. Record review revealed the resident was assessed to have had an increase in behavior symptoms. This MDS reveal that these symptoms occurred about 4-6 day indicating an increase in behavior for this resident.</p> <p>MDS dated 6/10/13 revealed that symptoms exhibited by resident put her at risk for physical illness or injury and interfered with resident's participation in activities or social interactions.</p> <p>Review of most recent Care Plan dated 5/13/13 revealed that resident goal was to have less than 2 episodes of physical abuse towards staff and others.</p> <p>In an interview with Staff B on 8/01/13 at 9 a.m., Staff B acknowledged that the most recent behavior disturbance care plan was last updated on 3/29/13 and did not include interventions to address the change in resident #171 increased behavior symptoms. Also record review of Social Services notes and Certified Nurse's Aide (NAC) Care Directives (CD) did not indicate any increased behavior interventions for Resident #171. This was also acknowledged by Staff B.</p>	F 279	<p style="text-align: right;">IDR AMENDED</p>	
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F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</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 periodically review and revise care plan interventions for 2 of 7 Sampled residents (#s 15 &amp; 16) reviewed for either pain management or urinary tract infections of the 46 residents who were included in the Stage 2 review. This failure placed the residents at potential risk for further falls and/or increased pain that is unrelieved.</p> <p>Findings include:  RESIDENT #15</p>	F 280			

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F 280	<p>Continued From page 20</p> <p>Refer to F 309 for more observations, interviews, and medical history.</p> <p>Resident #15 admitted on 8/1/12 with the active diagnoses of [REDACTED] with unknown etiology, and [REDACTED].</p> <p>On 7/24/13 at 11:26 a.m. Resident #15 was reported continual pain in the back/ tail bone area, hips and right shoulder with discomfort/ pain with no relief.</p> <p>On 7/26/13 at 11:00 a.m. Resident #15 complained of right shoulder pain while having ice pack on shoulder.</p> <p>On 7/29/13 at 12:14 p.m. Resident #15 reported pain shooting down the right arm to fingers with a pain level of 10 out of 10. Resident #15 stated "I'm kind of clutched here."</p> <p>Resident #15's current care plan for "Health Condition- Pain Care Plan" identified the resident having almost constant pain, which effected the resident's function. Pain manifested through facial expressions and vocalization. Some of the goals listed include resident to have pain relief for 30-60 minutes after administration of pain medication; to have decreased or no vocalization of pain and for the resident to have decreased or no resistance to care due to pain.</p> <p>The interventions included to evaluate pain on admission, quarterly, and as needed (PRN) with change in condition or ineffective pain management and to evaluate resident for effectiveness of routine/PRN pain medications every shift. Interventions also included evaluating</p>	F 280			

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F 280	<p>Continued From page 21</p> <p>for new, increase or declining in facial expression or mood changes.</p> <p>A doctor's order was written on 7/24/13 for Resident #5 to receive cold compress three times a day for pain to right shoulder. The "Health Condition-Pain Care Plan" was not updated with this new intervention for the resident. The care plan did not identify the interventions that best controlled Resident #15's pain that included use of cold compress three times daily and the most effective pain medication to relieve the resident's pain.</p> <p><b>RESIDENT #16</b></p> <p>Resident #16 was re-admitted on [REDACTED]/13 to the facility from a local hospital. The hospital history and physical documented Resident #16 was treated for a [REDACTED] versus [REDACTED]</p> <p>Minimum Data Set (MDS), a comprehensive assessment tool, dated 5/2/13 identified pertinent diagnoses for Resident #16's included [REDACTED]</p> <p>[REDACTED] The MDS identified the resident required extensive assist for bed mobility, toilet use, and personal hygiene, transfer, dressing and bathing.</p> <p>The 5/2/13 MDS triggered Care Area Assessment (CAA) for cognitive loss, visual function, communication, ADL functional/rehabilitation potential, urinary incontinence and indwelling catheter, falls, nutritional status, dehydration, and pressure ulcer to be care planned. For visual function it was identified that resident had decreased visual acuity related to macular</p>	F 280		
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F 280	<p>Continued From page 22 degeneration.</p> <p>Resident #16 had a fall on 5/10/13, 5/13/13, and 7/17/13. Previous interventions for Resident #16 for falls included implementation of "cue" signs to remind the resident to use the call light for help; to move the bed against the wall, and slip resistant strips added to floor next to the bed.</p> <p>The Resident #16's "Fall Risk Care Plan" was updated on 5/10/13 for the intervention of alarms added to the Resident's wheelchair, recliner, and bed. The facility did not revise care plan interventions following the second and third falls (on 5/13/13 or 7/17/13).</p> <p>On 7/26/13 at 10:14 a.m. Resident #16 was resting in recliner with alarm unplugged, and no call light in reach. When Resident #16 was asked, How would you get help if you needed it, the Resident shrugged shoulders.</p> <p>On 7/29/13 at 9:28 a.m. Resident #16 sat in a recliner with eyes closed. The call light was not in reach and the alarm on the recliner was unplugged.</p> <p>On 7/29/13 at 11:24 a.m. Resident #16 reported not being able to see the sign on the closet. The sign read "please use call light and wait for help". The facility did not reassess the resident to determine if "cue" signs were helpful</p> <p>On 7/30/13 at 2:40 p.m. Resident #16 sat in recliner with eye glasses on face. Resident was asked if able to read the sign on the closet, and he/she reported not being able to see the sign. When surveyor offered to clean the glasses, resident stated "that won't help".</p>	F 280			

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F 280	<p>Continued From page 23</p> <p>On 7/30/13 at 3:25 p.m. Staff B reported that care plans were evaluated and updated mostly by the Resident Care Managers, the MDS staff, and activities staff. When asked about the evaluation of the cueing sign intervention for Resident #16, Staff B could not answer and was made aware of the resident not being able to see the sign. Staff B reported that the sign is not only for the resident but also to alert the staff that the resident is a fall risk.</p> <p>On 7/30/13 at 3:50 p.m. Staff NN reported that the sign is for Resident #16 to remind to call for help because the resident has fallen so the sign was put up as a reminder.</p> <p>The facility failed to reassess and/or evaluate whether Resident #16 was able to see and read the cueing sign and understand it. This failure placed the resident at potential risk for future falls and/or injuries.</p>	F 280		
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility did not follow its total parental nutrition (TPN) administration standards of practice for Resident # 17.</p> <p>Findings include:</p>	F 281	<p style="text-align: right;">IDR AMENDED</p>	

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F 281	Continued From page 24  The facility did not follow its TPN guidelines for line maintenance, rate and volume, orders, hang times, infusion durations, bag labeling, documentation, rate adjustments, tracking amounts per day infused, and problem-solving administration interruptions, as follows:  On 7/30/13 at 3:26 pm Staff WW was asked the time Resident #17 TPN would be stopped to observe the process. Staff WW stated she/he did not do anything with the TPN, that "was done on night shift." Staff RR told Staff WW the TPN was stopped on eve and started at night. Staff RR was unable to locate the residents MAR sheets and began to search. At 3:45, surveyor returned to with Staff WW who stated s/he had found next months' MAR with orders. When reading the TPN order, Staff WW stated she/he was unsure of what to do. Asked the surveyor whether the order was flushed with 10 milliliters (ml) or 20 ml or if should flush line at all? Staff WW as directed to get assistance when Staff B walked up to desk. Staff WW explained she/he did not understand the orders for flushing the PICC line and again asked for help understanding what to do with the PICC line. Staff B explained the order to Staff WW for flushing the PICC line after stopping the TPN. Staff B explained that Staff WW was filling in on that hallway that day and was usually on other run/unit, this hallway not her usual unit.  On 7/30/13 at 3:58 p.m., Staff WW was observed discontinuing the TPN for Resident #17. Staff WW confirmed the IV rate was infusing at 180 ml an hours with 205 ml remaining to be infused,	F 281		

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F 281	<p>Continued From page 25</p> <p>though the rate should have been decreased to 90 ml an hours at 3:00 p.m., Staff WW disconnected the IV fluid from the PICC line port, cleaned the port with alcohol wipes several times then flushed each port with 10 ml of normal saline. Staff WW was asked to see the PICC line site that was covered by the residents sleeve. Staff WW pulled back Resident # 17 sleeve to show the IV site was clean, dry, intact, the dressing was secure, and dated and initialed was changed on 7/28/13. The pharmacy label on the TPN bag was listed to have a total volume of 2750 ml with 2700 ml to be infused and a notation on the bottom to add 24 units Regular of Insulin to the bag. The IV bag was not signed or dated and did not label that insulin had been added. Staff WW confirmed the IV bag was not labeled correctly, that the information not being on the bag "that is not right." At 4:15 p.m. Staff B stated it is her expectation for labels on IV to be filled out. Review of MAR records by Staff B showed the nurse had initialed insulin was added to the IV bag.</p> <p>7/30/13 at 4:20 p.m. when asked the reason for the adjustments in the IV rate at the beginning and end of the infusion, Staff B stated the purpose of the decrease in IV rate from 180 ml an hour down to 90 ml and hour for one (1) hour before discontinuing the TPN, she/he thought was for absorption.</p> <p>At 4:55 p.m. on 7/30/13 Staff B stated the reason for the TPN rate tapering was glucose stabilization. The physician and pharmacist had been called and informed of the rate change not being done as ordered when the TPN was</p>	F 281	<p style="text-align: right;">IDR AMENDED</p>	

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F 281	<p>Continued From page 26</p> <p>stopped then stated, it "is a medication error" and would write an incident report.</p> <p>The July 2013 MAR records Multivitamins (MVI) 10 ml were to be added to the TPN bag every other day (QOD) at 2300 (11:00 p.m.) and was schedule for 7/30/13. On 7/31/13 at 10:21 a.m. the TPN bag for Resident # 17 was labeled, dated and signed to have insulin added but did not list the MVI. At 11:30 a.m. Staff B and Staff QQ when looking at the Medication Administration Record (MAR) with the MVI not initialed, stated the MVI was not given. When both viewed the IV bag, Staff B stated "looks like the MVI is not in there."</p> <p>A review of the MAR by Staff B also revealed the insulin not been initialed as added, but was signed as given on the IV bag. Staff B stated entering initials mean the medications was given and you are the one that has given them. Initials mean that the additives were put in the bag. Staff SS initials were identified as marked incorrectly under the date for the following day.</p> <p>On 7/31/13 at 10:29 am Staff FF confirmed that when looking at the label on the TPN bag that the MVI had not been added to bag. Stated when no initials on the MAR for MVI, means was not given; the bag should have insulin and MVI initialed.</p> <p>During this observation the remaining fluid to be infused was 205 ml not counting the 50 ml overfill. Staff WW was observed to remove the bag from the IV machine and prepare for discard.</p>	F 281	<p style="text-align: right;"><b>IDR AMENDED</b></p>	
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F 281	Continued From page 27 No action was taken to contact the provider regarding the volume remaining before discarding the bag.  On 7/31/13 at 11:30 am Resident #17's TPN bag was noted to have 2101 ml of fluid remaining. At 3:20 the IV rate noted infusing at 90 ml an hours with 1648 ml remaining to be infused. Staff PP stated had just observed the residents IV and looks ok. When asked about the 1648 ml TPN volume remaining to be infused, Staff PP stated she/he believed a page went out to the provider on the resident, then walked over to the nurses ' desk and made a phone call.  On 8/1/13 Staff B stated was aware residents the IV pump for Resident # 17 was off on 7/31/13, she/he had found it off. Stated the IV was usually not off more than 15 minutes. The remaining volume of 1648 ml equals approximately 8.8 hours of missed IV fluid infusing at 180 ml an hours; more than the 15 minutes assumed. Orders from the physician to notifying the provider of TPN volume remaining to be infused was not received until the issue was brought to the attention of Staff L, Staff K and Staff QQ on the afternoon of 8/1/13.	F 281			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282			

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F 282	<p>Continued From page 28</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review it was determined that the facility failed to consistently implement the care plan for 1 of 4 Sampled Residents (#16) reviewed for accidents of the 46 residents who were included in the Stage 2 review. This failure placed the resident at potential risk for future falls and/or injuries.</p> <p>Findings Include:</p> <p>RESIDENT #16: Resident #16 was admitted on [REDACTED]/13 to facility after hospitalization for [REDACTED] ([REDACTED])</p> <p>Resident #16's significant change Minimum Data Set (MDS), a comprehensive assessment dated 5/2/13 identified pertinent diagnoses for Resident #16's as [REDACTED]</p> <p>[REDACTED] in this MDS resident was assessed as being an extensive assist for bed mobility, toilet use, personal hygiene, transfer, dressing and bathing.</p> <p>The 5/2/13 MDS triggered Care Area Assessment (CAA) for cognitive loss, visual function, communication, ADL functional/rehabilitation potential, urinary incontinence and indwelling catheter, falls, nutritional status, dehydration, and pressure ulcer to be care planned. For visual function it was identified that resident had decreased visual acuity related to macular degeneration.</p> <p>The 5/2/13 MDS triggered a CAA for falls which identified Resident #16 as a fall risk, with the</p>	F 282		
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F 282	<p>Continued From page 29</p> <p>internal risk factors listed as circulatory/heart (HTN, CHF), neuromuscular/functional (incontinence, weakness), perceptual (visual, hearing impairments), psychiatric or cognitive (anxiety, depression), and infection (UTI and pneumonia). The CAA analysis documented that Resident #16 at risk for falls related to impaired cognition and impaired communication skills. Resident #16 is incontinent and had received a diuretic which increased fall risk.</p> <p>An "Event Investigation Report," a form used by the facility to document investigations of incidents, dated 5/10/13 identified Resident #16 trying to self-transfer from wheelchair to recliner. An "Event Investigation Final Summary," a conclusion of the investigation that documented the resident having a history of falls and had decreased safety awareness secondary to dementia. Previous interventions put in place to prevent reoccurrence were cue signs to use call light for assistance, non-slip floor strips next to bed, and bed against the wall. Going forward the plan to prevent reoccurrence was to implement an alarm to wheelchair, bed, and recliner.</p> <p>An "Event Investigation Report" dated 5/13/13 identified Resident #16 was again trying to self-transfer from wheelchair to recliner. Staff KK heard someone calling help and the sound of the alarm and followed it to find Resident #16 on the floor. The resident was again documented to have a history of falls and decreased safety awareness due to confusion. During data collection it was identified resident having an increase in falls, strong odor of urine with dark yellow color. The plan to prevent reoccurrence after this fall was to obtain a urine sample to check for a UTI and have physical therapy screen</p>	F 282	<p style="text-align: right;">IDR AMENDED</p>	
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F 282	<p>Continued From page 30</p> <p>for strength potential. Physical therapy services/intervention not on fall care plan and No changes were made to the care plan.</p> <p>An "Event Investigation Report" dated 7/17/13 identified Resident #16 trying to self-transfer from wheelchair to recliner. The "Investigator's Interview/Statement of Event" filled out by Staff AAA documented being in room 503 doing care and heard someone yelling help. There was no mention of an alarm sounding on the "Investigator's Interview/Statement of Event" or on the analysis of all the information on the "Event Investigation Final Summary." The plan to prevent reoccurrence was to send a urine analysis and to be seen by therapy for decline in function. (PT recommended continuation with restorative nursing program.)</p> <p>On 7/24/13 at 1:24 p.m. Resident #16 was resting in recliner with call light on bed not in reach and at 1:53 p.m. call light still observed not in reach for the resident.</p> <p>On 7/25/13 at 8:28 a.m. Resident #16 sitting in recliner adjacent to the bed that is against the wall, the call light was at foot of the bed on the floor within the resident's reach.</p> <p>On 7/25/13 at 9:50 a.m. call light remained at the foot of the bed on the floor out of reach, while resident was sitting in the recliner.</p> <p>On 7/26/13 at 10:14 a.m. Resident #16 resting in recliner, call light not in reach and alarm on the recliner was unplugged and resting on the bed. When asked how you would get help if you needed it, Resident #16 shrugged shoulders. Resident #16 asked for helping finding</p>	F 282	<p style="text-align: right;">IDR AMENDED</p>	

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F 282	<p>Continued From page 31</p> <p>something, and staff was made aware of resident needing assistance. At 10:17 a.m. staff went into resident's room to assist and then came out. At 10:23 a.m. Resident #16 remained sitting in recliner with alarm still unplugged and call light was behind the resident's back, not in reach.</p> <p>On 7/26/13 at 12:24 p.m. Staff FF reported that if a resident cannot use the call light we check on them every 2 hours to see if they need anything.</p> <p>On 7/29/13 at 9:28 a.m. Resident #16 had "cue" sign on closet that read "please use call light and wait for help." Resident #16 was sitting in recliner and resting with eyes closed; call light not in reach, and alarm not plugged in.</p> <p>On 7/29/13 at 10:40 a.m. Staff B confirmed that alarms will not prevent falls. Staff B reported that fall interventions are evaluated by staff, and the fall committee.</p> <p>On 7/29/13 at 11:08 a.m. Staff B and Staff QQ were taken to Resident #16 room and were shown that the resident is resting in recliner with call light behind resident's back not in reach, and the recliner alarm was not plugged in. Staff B confirmed that the alarm was not plugged in and call light was not in reach. These interventions were not in use to prevent a fall.</p> <p>On 7/29/13 at 11:24 a.m. Resident #16 denied being able to read the cue sign on the closet, reminding resident to use call light.</p> <p>On 7/30/13 at 10:54 Staff GG reported that if Resident #16's call light was not in reach the resident just yells out for staff. Staff GG reported that the resident off and on knows to use the call</p>	F 282	<p style="text-align: right;">IDR AMENDED</p>	

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F 282	<p>Continued From page 32 light.</p> <p>On 7/30/13 at 2:40 p.m. Resident #16 sitting in recliner with glasses on and was asked if able to read the sign he/she replied no. Offered to clean glasses and Resident #16 stated "that won't help"</p> <p>On 7/30/13 at 3:25 p.m. Staff B reported that interventions on the care plans were evaluated mostly by resident care managers, and MDS staff when initiated by the CAA on a quarterly basis. Staff B reported that the effectiveness of the care plan is ongoing. When asked about Resident #16's "cue" sign on closet, Staff B reported that the sign is not only for the resident but also to alert staff that the resident is a fall risk.</p> <p>On 7/30/13 at 3:50 p.m. Staff NN reported the "cue" sign on the closet was for Resident #16 to remind to call for help because the resident has fallen so staff put up the sign as a reminder.</p> <p>On 8/1/13 at 10:38 a.m. Staff QQ reported that if interventions were not changed on the care plan then the interventions were appropriate at the time for the fall risk.</p> <p>On 8/5/13 at 2:48 p.m. Staff E reported that Resident #16's UTI have something to do with the falls, when the resident falls staff finds out a UTI is present. Staff E reported that Resident #16 gets more confused when having a UTI. When asked if it had been considered to move resident closer to nurses' station to provide closer supervision, Staff E reported that it has not been considered.</p> <p>The facility was aware of Resident #16's history</p>	F 282	<p style="text-align: right;"><b>IDR AMENDED</b></p>	
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F 282	Continued From page 33 of falls, and decreased safety awareness due to confusion. Resident #16 had 3 non-injury falls on 5/10/13, 5/13/13, and 7/17/13. Multiple observations were made at the time of survey where the resident's call light was not in reach and the resident's alarm was connected while sitting in the recliner. Failure to implement the care plan to prevent falls placed the resident at risk for future potential falls and potential injury.	F 282		
F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to provide effective pain management and/or failed to identify and monitor a non-pressure related skin condition for 2 of 6 Sampled Residents (#s 15 &amp; 136) reviewed for pain and/or skin condition of the 46 residents who were included in the Stage 2 review.</p> <p>Findings Include: PAIN MANAGEMENT</p> <p>RESIDENT # 15: Resident #15 admitted on [REDACTED] 12 with active</p>	F 309	<p style="text-align: center;">IDR AMENDED</p>	

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F 309	<p>Continued From page 34</p> <p>diagnoses of [REDACTED]</p> <p>Minimum Data Set (MDS) dated 6/21/13 identified Resident #15 as cognitively intact and having total dependence on staff for bathing, toilet use, personal hygiene, dressing and eating. MDS documented Resident #15 having a pain level of 10 on a pain scale of 0 to 10 (10 being the worst possible pain) and receiving routine and as needed (PRN) pain medications.</p> <p>An undated "Pain Evaluation" documented the resident had pain due to upper and lower extremity contractures resulted from a progressive neuromuscular disease.</p> <p>A "Pain Evaluation" dated 1/22/13 documented the resident reported chronic pain due to contractures and described pain at level 4 (on 0 to 10 pain scale, 10 being the worst possible pain). Additional evaluations dated 2/22/13; 3/14/13 and 4/11/13 also documented pain levels to be between 3 to 5. "Pain Evaluations" dated 1/22/13; 2/22/13; 4/11/13 and 6/26/13 all identified pain effected Resident #15's quality of life and ability to participate in restorative efforts. All but the 2/22/13 evaluation documented pain also impacted the resident's ability to perform Activities of Daily Living.</p> <p>None of the before mentioned "Pain Evaluations" reviewed identified if the pain levels noted described a current pain level or if they were ranges of pain intensity the resident experienced throughout the day. None of the evaluations identified what factors worsened the resident's pain or if the resident was satisfied with the current pain control program. The evaluations did</p>	F 309	<p style="text-align: right;">IDR AMENDED</p>	

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F 309	<p>Continued From page 35</p> <p>not identify if or what non-pharmacological interventions were attempted to reduce pain or if any were effective.</p> <p>Multiple times the facility altered the resident's pain medication program. The "Pain Evaluation" dated 2/22/13 documented staff obtained an order to add [REDACTED] 2 milligrams (mg) given as needed to the pain (PRN) management program. The evaluation dated 3/14/13 documented [REDACTED] was changed to be given on a routine basis instead of as needed (PRN).</p> <p>In addition to the dilaudid changes, July 2013's medication record identified the physician ordered [REDACTED] 5mg given PRN on 6/11/13.</p> <p>The July 2013 medication record documented staff administered routine dilaudid every six hours at 3:00 a.m.; 9:00 a.m.; 3:00 p.m.; and 9:00 p.m. The record also identified staff administered a [REDACTED] every four hours PRN for breakthrough pain. The record identified staff documentation Resident #15 received PRN pain medication once or twice a day as needed for breakthrough pain not effectively treated with routine prescribed [REDACTED]</p> <p>On 7/24/13 at 11:26 a.m. Resident #15 reported having continual pain in the back, tail bone, hips and right shoulder with no relief and had received routine pain medication earlier at 9:00 a.m., approximately two and half hours earlier.</p> <p>Record review of "July 2013-Rehab and Restorative" flow sheet documented 18 attempts/therapy sessions provided out of 24 sessions that were referred. On the restorative program notes for Resident #15 on 7/24/13</p>	F 309	<p style="text-align: right;">IDR AMENDED</p>	
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F 309	<p>Continued From page 36</p> <p>documented that the resident refused treatment today, stated shoulder was hurting too much and was having some discomfort so to try again tomorrow.</p> <p>On 7/24/13 staff documented on the July 2013 "Pain Management Flowsheet" Resident #15 reported pain levels of 3-5 out of 10 during the day and evening shifts. The flow sheet did not identify what time the resident reported having pain. The July 2013 medication record identified staff administered PRN pain medication three times on 7/24/13. The record did not contain evidence staff identified the time they administered the pain medication; assessed the resident's pain at the time of administration or attempted non-pharmacological interventions to alleviate pain. The record did not contain evidence staff monitored to determine if PRN pain medication was effective.</p> <p>On 7/26/13 at 11:00 a.m. Resident #15 complained of right shoulder pain while having ice pack on shoulder.</p> <p>The "Pain Management Flowsheet" staff documented on 7/26/13 "dashes" or did not have pain that day. On 7/31/13 at 9:42 a.m. when asked how staff assessed for pain and if Resident #15's pain level was assessed at 9:00 a.m. (at the time staff administered routine [REDACTED]. Staff FF reported when giving the 9:00 a.m. [REDACTED] the resident was not asked the level of pain at that time. Later at 10:25 a.m., Staff FF reported dashes on the flow sheet indicated the resident did not tell staff he/she had pain.</p> <p>The July 2013 medication record for 7/26/13 contained initials staff administered PRN pain</p>	F 309	<p style="text-align: center;">IDR AMENDED</p>

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F 309	<p>Continued From page 37</p> <p>medication twice. The record did not identify if staff assessed the resident's pain level, location or attempted non-pharmacological interventions prior to administration of the PRN pain medication or monitored if the pain medication was effective. The record did not contain evidence staff evaluated the effectiveness of the use of the ice pack that was in place.</p> <p>On 7/29/13 at 12:14 p.m. Resident #15 reported pain shooting down the right arm to the fingers with a pain level of 10 out of 10. Resident #15 stated "I'm kind of clutched here, I need therapy." Resident #15 reported that restorative staff had not shown up since Wednesday (7/24/13) and it was declined due to pain. The "Pain Management Flowsheet" documented during day shift on 7/29/13 Resident #15 reported having pain at level 3 to 5. The July 2013 medication record did not identify that staff offered or administered breakthrough pain medication to Resident #15 on 7/26/13 to alleviate pain prior to the restorative session.</p> <p>Progress notes dated 7/29/13 documented during evening shift "resident remains very needy constantly calling out from room for help or has call light on PRN pain med usage along with routine dilaudid TID." The "Pain Management Flowsheet" for July 2013 documented the resident verbally reported pain level of 3-5 out of 10. The July 2013 medication record did not contain documentation to indicate staff administered any breakthrough pain medication during any shift on 7/29/13.</p> <p>On 7/30/13 at 10:09 a.m. Resident #15 complained of pain while turning during observation of dressing change. Resident #15</p>	F 309	<p style="text-align: center;">IDR AMENDED</p>	

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F 309	<p>Continued From page 38</p> <p>instructed staff on how to assist with turning and moving extremities while repositioning in bed. Resident #15 reported not being able to turn on sides due to shoulder and clavicle pain from contractures. A Care Area Assessment (CAA) dated 11/8/12 documented the resident noncompliant with turning. The record did not contain evidence staff comprehensively assessed the association of pain and refusals for repositioning.</p> <p>On 7/31/13 at 9:34 a.m. Resident #15 reported "excruciating pain" at a pain level of 9 out of 10 when asked by surveyor. Resident reported not getting much sleep due to stabbing pain from right thumb to the right side of neck. The resident also reported waking up with pain during the middle of the night at 3:30 a.m. and described the pain level at 10.</p> <p>On 7/31/13 at 10:08 a.m. Resident #15 reported during the night at 3:30 a.m., he/she told Staff TT about having pain and wanted pain medication and did not receive pain medication scheduled for 3:00 a.m. until after 5:00 a.m., over two hours later. Resident #15 reported that the pain is best managed with ice packs, vicodin (pain medication), and restorative therapy.</p> <p>On 8/1/13 at 12:35 p.m. Resident #15 confirmed that if pain was better managed then he/she would be able to do more.</p> <p>During record review of Resident #15's current care plan for "Health Condition-Pain Care Plan" most recently reviewed on 6/26/13 identified resident had almost constant pain, which affected the resident's function. Pain manifested through facial expressions and vocalization. Some of the</p>	F 309	IDR AMENDED	
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F 309	<p>Continued From page 39</p> <p>goals listed included for the resident to have pain relief for 30-60 minutes after administration of pain medication; to have decreased or no vocalization of pain, and for the resident to have decreased or no resistance to care due to pain.</p> <p>The interventions included to evaluate pain on admission, quarterly, and as needed (PRN) with change in condition or ineffective pain management and to evaluate resident for effectiveness of routine/PRN pain medications every shift. Interventions also included evaluating for new, increase or declining in facial expression or mood changes.</p> <p>The facility failed to consistently and comprehensively assess Resident #15's pain prior to administration of pain medications. Resident #15's pain level was not consistently evaluated after pharmacological interventions were provided. This failure prevents the facility from accurately evaluating whether the pain management program in place for Resident #15 is effective. The pain care plan was not updated with non- pharmacological interventions that assisted the resident with pain management and the pharmacological interventions that identified to worked best for Resident #15. Failure to complete a thorough assessment prior to each intervention and not evaluating the intervention that was provided placed the resident at risk for further pain with no relief and a decreased quality of life.</p> <p><b>NON PRESSURE SKIN CONDITION</b></p> <p>RESIDENT #136 Resident #136 was admitted to the facility on [REDACTED] 12.</p>	F 309	<p style="text-align: center;">IDR AMENDED</p>	

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F 309	<p>Continued From page 40</p> <p>Review of the 7/10/13 MDS revealed diagnoses of S [REDACTED]</p> <p>On 7/24/13 at 3:20 p.m. Resident #136 was observed with areas to bilateral hands and right forearm that were bruise-like.</p> <p>Review of the record revealed the resident had recently returned from the hospital after he/she had suffered a [REDACTED]. The resident was readmitted to the facility [REDACTED]/13. The resident had been prescribed to take [REDACTED]. The 7/11/13 admission evaluation did not identify any bruising at that time.</p> <p>On 7/29/13 at 11:44 a.m. the resident was observed sitting in a wheelchair with the same bruise-like areas still present to the hands and right forearm. This resident was not interviewable.</p> <p>On 7/31/13 at 1:53 p.m. Resident #136 was observed lying down in bed. The same areas were observed with bruise-like areas still present.</p> <p>On 7/31/13 at 2:53 p.m. Staff AA was asked about the facility's process for skin checks. Staff AA stated that skin checks were done weekly and then once weekly after that. Staff AA confirmed that bruises of any size were to be identified on their skin sheets and monitored. Staff AA denied noting any bruising on Resident #136.</p> <p>On 7/31/13 at 2:59 p.m. Staff N stated that most residents get weekly skin checks and that bruising should be noted and monitored. Staff N was not able to recall any bruising on Resident #136, however, added that if bruising were present she/he might hold the [REDACTED] as that could</p>	F 309	<p style="text-align: center;">IDR AMENDED</p>	
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F 309	<p>Continued From page 41 be an indication of bleeding.</p> <p>On 7/31/13 at 3:40 p.m. Staff D stated residents get weekly skin checks and were also looked at on shower days. Staff D indicated any abnormality of the skin would be noted on the skin sheet and monitored. At 4:00 p.m. (7/31/13) went to observe Resident #136 with Staff D present. Staff D indicated the areas on the hands were petechiae or purpura (discoloration due to bleeding underneath the skin) and would be watched but not something they would place on the skin sheet to track. The bruise to the right forearm, however, Staff D stated "should be measured and placed on the skin sheet." Staff D measured this area at 1.2cm by 0.8cm and added that the bruise "looked old."</p> <p>On 8/2/13 at 9:40 a.m. went with Staff Q to Resident #136's room. Staff Q confirmed the area on the right forearm was a bruise and should be monitored. Staff Q also indicated that the bruise to the right forearm "looks like an old bruise."</p> <p>Review of the Anticoagulation Therapy Care Plan in place for this resident stated the "Resident will not show any s/s (signs or symptoms) of generalized bleeding e.g. bruises, petechiae." Interventions in place were to do daily body checks and to report new areas of bruising.</p> <p>The failure to identify the condition of Resident #136's skin or to monitor and objectively measure bruising placed this resident at risk for undetected bleeding related to being on an anti-coagulant; delayed healing and/ or the development of new wounds.</p>	F 309	<p style="text-align: center;">IDR AMENDED</p>	
F 311	483.25(a)(2) TREATMENT/SERVICES TO	F 311		

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F 311 SS=D	<p>Continued From page 42</p> <p><b>IMPROVE/MAINTAIN ADLS</b></p> <p>A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on Observation, interview and record review, it was determined the facility failed to consistently provide restorative nursing services to 1 of 2 current sampled dependent residents (#59) reviewed for community discharge out of 30 admission sample residents. This failure placed the resident at risk for decline in his/her ability to perform Activities of Daily Living (ADLs)</p> <p>Findings include:</p> <p>Resident admitted to facility on [REDACTED] 13 with multiple diagnoses which included [REDACTED] weakness.</p> <p>The most recent Restorative Care Plan (RCP) dated 7/3/13 revealed the resident was planned to participate in a upper body strengthening exercises and ambulation six (6) times a week.</p> <p>Review of the most recent Resorative Program Flow Sheet for the month of July 2013, revealed the restorative exercises did not occur on the following days as planned: 7/6/13, 7/7/13, 7/8/13, 7/16/13, 7/19/13, 7/20/13 and 7/27/13.</p> <p>On 7/29/13 at 10:00 a.m. Resident #59 reported the restorative services were not consistently provided as schedule. Resident #59 stated "Restorative staff come whenever they can come"</p>	F 311	<p style="text-align: center;">IDR AMENDED</p>	

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F 311	Continued From page 43  On 7/28/13 at 2:30 p.m. Resident #59 was observed sitting in a chair in his/her room. The resident reported missing restorative services which were scheduled for the morning. Resident #59 reported he/she had asked the doctor if he/she could start walking independently. The doctor advised the resident to always walk with the assistance of staff.  On 7/29/13 at 11:03 a.m. Staff JJ was asked how many time Resident #59 was planned to participate in the restorative program. Staff JJ stated "The resident gets to participate in Restorative Program when I can get to him. Sometimes am unable to get to him because I have a large workload."  On 07/29/13 at 11:22 a.m., Staff B stated that she/he was not aware that the resident was not consistently participating in the restorative Program. At this time Staff B reviewed the restorative flow sheet and acknowledged Resident #59 had not consistently participated in the Restorative Program.	F 311			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315		IDR AMENDED	



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F 315	<p>Continued From page 45</p> <p>catheter, falls, nutritional status, dehydration, and pressure ulcer to be care planned. CAA analysis for incontinence identified that resident had increased risk for skin breakdown and UTI.</p> <p>Resident #16 has a history of [REDACTED] and was treated in the hospital from 4/22/13 - 4/25/13.</p> <p>On 7/29/13 at 10:55 a.m. Staff B confirmed that Resident #16 was not care planned for urinary incontinence and/or UTI.</p> <p>On 8/1/13 at 8:38 a.m. Resident #16 sitting in recliner with headphone on and eyes closed.</p> <p>On 8/1/13 at 9:21 a.m. Staff HH reported that Resident #16 is to be cared for in pairs, the resident is incontinent and it takes two people to move her. Staff HH reported that Resident # 16 wears a brief and is not toileted, but changed in bed.</p> <p>On 8/1/13 at 12:12 p.m. Perineal care observed for Resident #16 provided by Staff FF and Staff HH. The brief removed was wet with dark yellow urine and strong odor.</p> <p>On 8/1/13 at 12:35 p.m. Staff HH reported checking on Resident #16 around 9:00 a.m. and then again twenty minutes later and the resident was a little wet. Staff HH reported having to wait for another staff member to assist with care. Resident #16 had a wet brief since approximately 9:41 a.m. as reported by Staff HH.</p> <p>On 8/1/13 between approximately 9:41 a.m. until 12:12 p.m., (over 2 hours) Staff HH confirmed staff did not provide incontinent care for Resident #16.</p>	F 315	<p style="text-align: right;">IDR AMENDED</p>	

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F 315	<p>Continued From page 46</p> <p>On 8/1/13 at 2:43 p.m. Resident #16 reported not knowing when he/she needed to go to the bathroom or when his/her brief was wet.</p> <p>On 8/1/13 at 3:00 p.m. Staff NN confirmed that the certified nurse aides (CNA) do a shift report, but Resident #16's elimination schedule was not discussed.</p> <p>On 8/2/13 at 9:11 a.m. Staff GG reported the resident is checked for incontinence every 2 hours, and if wet the resident brief is changed. Staff GG reported Resident #16 is usually wet when coming on shift in the morning, the resident is cleaned up, changed and dressed and then probably changed one more time on day shift.</p> <p>On 8/2/13 at 9:56 a.m. Staff F reported that a UTI from Escherichia coli (a bacteria commonly found in the lower intestine) was caused by poor perineal care. Staff F reported that Resident # 16's UTI(s) were due to improper perineal care, not drinking enough water, and as the resident gets weak the amount of bacteria rises. Staff F reported recently training licensed staff of this topic on 4/25/13.</p> <p>No evidence was found in Resident #16's record that staff developed a plan of care to identify the resident's needs related to prevention of increased urinary incontinence, such as frequency and urgency of elimination. This failure placed the resident at risk for decreased quality of life.</p> <p>RESIDENT #171 Resident #171 was admitted to facility [REDACTED] 13 with multiple diagnoses which included</p>	F 315	<p style="text-align: right;"><b>IDR AMENDED</b></p>	
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F 315	Continued From page 47 ██ 03/26/13 reveal resident was assessed to be frequently incontinent of urine.  The MDS dated 6/10/13 revealed the resident was re-assessed to have had a decline in urinary function.  Review of the urinary incontinence care plan (CP) revealed care plan was last reviewed 5/30/13. This care plan did not include any interventions to address the resident's decline in urinary function.  Record review of the most recent Certified Nurse's Aide (CNA) Care Directives (CD) posted in resident's closet were not dated and did not include any interventions to address resident's decline in in urinary function.  On 7/31/13 at 1:35 p.m., Staff B acknowledged that elimination care plan had not been updated to address resident #171's decline in urinary function and stated "the care plan should have been updated to address resident's change but it was missed."	F 315			
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS  The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and	F 328			

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F 328	<p>Continued From page 48 Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility did not follow its total parental nutrition (TPN) administration guidelines for TPN administration for sampled Resident #17.</p> <p>Findings include:</p> <p><b>FLUID ADMINISTRATION</b> Resident #17 was admitted to the facility with Total Parenteral Nutrition (TPN), a solution containing all the required nutrients including protein, fat, calories, vitamins, and minerals given intravenously (IV) through the resident's vein.</p> <p>The Interdisciplinary Progress Notes (IPN) documented between 5/23/13 through 7/25/13 sixteen (16) entries when the resident was noted to turn off his/her intravenous (IV) pump for TPN. Review of the record did not direct staff of what to do in the event the resident did not receive the ordered amount of TPN fluid.</p> <p>Review of the Physician order dated 5/11/13 directed staff to infuse the TPN at 90 milliliters (ml) an hour for one hour then increase to 180 ml and hour for 14 hours then decrease to 90 ml an hour for 1 hour daily. The resident's TPN was to start at 11:00 p.m., and stop at 4:00 p.m.</p> <p>On 7/30/13 at 3:58 p.m., the TPN was observed to be infusing at 180 ml an hour when Staff WW</p>	F 328	<p style="text-align: right;"><b>IDR AMENDED</b></p>	

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F 328	<p>Continued From page 49</p> <p>stopped the IV. Staff WW removed the TPN bag which contained 205 ml of fluid from the resident's room.</p> <p>On 7/30/13 at 3:58 p.m., during an interview, Staff WW confirmed the IV rate was infusing at 180 ml per hour before she/he stopped the IV.</p> <p>On 7/30/13 at 4:55 p.m., the DNS stated the nurse should have turned down the IV to 90cc an hour before stopping the IV. The DNS stated she would complete an incident report related to this event.</p> <p><b>FLUID VOLUME</b></p> <p>The physician order that directed staff to turn on the IV at 11:00 p.m. and stop the IV at 4:00 p.m. was not correctly administered.</p> <p>Observations on 7/31/13 at 3:20 p.m., revealed the resident lying in bed on his back with eyes open. The Resident's IV was infusing TPN fluid at a rate of 90 ml per hour. According to the physician's order the IV should be stopped at 4:00 p.m. The reading on the IV pump at 3:20 p.m., showed 1648 ml of TPN fluid remaining. The volume of TPN fluid that remained identified the resident had not received the correct amount according to the physician's order.</p> <p>Although the IPN notes documented the resident would turn off his IV pump, there was no order to direct staff of what to do when TPN fluid</p>	F 328	<p style="text-align: right;"><b>IDR AMENDED</b></p>	

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F 328	<p>Continued From page 50</p> <p>remained that had not been infused. On 7/31/13 at 3:30 p.m., when Staff PP was asked about the remaining amount of fluid to be infused; Staff PP stated she believed a page had gone out to the doctor about the resident's remaining TPN.</p> <p>On 8/1/13 review of the record did not show that the physician had been notified of the amount of fluid that remained in the bag when the TPN had been stopped.</p> <p>On 8/1/13 at 2:24 p.m., interview with the registered dietician (Staff K), regional registered dietician (Staff L) and the investigative nurse (Staff QQ) regarding expected staff interventions when Resident #17 had 1648 ml of TPN fluid remained that should have already been infused before the TPN was scheduled to be stopped. Staff L responded she/he would have possibly continued running the IV.</p> <p>After the interview with Staff K, Staff L and Staff QQ, review of the record revealed a physician's order dated 8/1/13 at 4:00 p.m., directed staff to notify the physician when Resident #17 had over 400 ml of TPN fluid that remained and had not been infused according to the physician's original order.</p> <p>Refer to Ftag 281 for further evidence how the facility did not follow its TPN standards of practice guidelines for line maintenance, rate and volume, orders, hang times, infusion durations, bag labeling, documentation, rate adjustments, tracking amounts per day infused, and problem-solving administration interruptions.</p>	F 328			
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329			

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F 329 SS=D	<p>Continued From page 51 <b>UNNECESSARY DRUGS</b></p> <p>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.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to adequately monitor behaviors or sleep patterns to ensure adequate indication for medication use for 1 of 10 Sampled Residents (#189) reviewed for unnecessary medications of the 46 residents who were included in the Stage 2 review. This failure placed the resident at potential risk to receive unnecessary medications.</p>	F 329	<p style="text-align: right;"><b>IDR AMENDED</b></p>	
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F 329	<p>Continued From page 52</p> <p>Findings Include:</p> <p><b>RESIDENT #189</b> Resident #189 was admitted to the facility [redacted] 5/13 with diagnoses of [redacted] and [redacted] disorder. This resident was also assessed to require [redacted] services upon admission. Review of the MDS (Minimum Data Set- an assessment tool) dated 5/14/13 indicated the resident did not require the use of anti-psychotic or anti-anxiety medications.</p> <p>Record review revealed on 5/27/13 [redacted] (a medication used to treat insomnia) was added to the regimen to be given every night. On 6/27/13 [redacted] (an anti-anxiety medication) was added as needed (PRN) for anxiety. On 7/2/13 [redacted] (an anti-psychotic medication) was added. Additionally, on 7/10/13 [redacted] (an anti-psychotic medication) was added to treat "[redacted]" Record review revealed no evidence staff identified or monitored behaviors or tracked sleeping patterns which required the use of these drugs.</p> <p>On 7/30/13 at 4:09 p.m. Staff O stated that generally everyone on these types of medications should be monitored for behaviors but was unable to find any monitoring.</p> <p>On 7/31/13 at 10:32 a.m. Staff N was asked what behaviors Resident #189 exhibited which required the use of the anti-psychotic and anti-anxiety medications. Staff N stated "for [redacted] he/she sometimes kicks in the air...for the [redacted] I think he/she hallucinates." Staff N added that this</p>	F 329	<p style="text-align: right;"><b>IDR AMENDED</b></p>	

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F 329	<p>Continued From page 53</p> <p>resident was on Hospice and confirmed that no behavior or sleep monitoring was being done.</p> <p>On 7/31/13 at 1:25 p.m. when asked if residents on [REDACTED] medications were typically monitored for behaviors Staff H stated yes and added that Social Services staff were in charge of initiating this. When asked about Resident #189 not being monitored Staff H confirmed that this resident should be monitored for behaviors as well as sleep patterns and stated "I missed it." Staff H added that usually Social Services is informed of medication changes at their daily meetings. Staff H stated "Usually the communication is really good...throwing in other services like hospice makes things muddy..."</p> <p>On 7/31/13 at 1:40 p.m. Staff C was asked about Resident #189's lack of behavior monitoring. Staff C stated "Hospice has taken over." Staff C was then asked how staff knew if the medications were being effective if there was not any monitoring in place. Staff C indicated that Hospice visited frequently and stated "We go off of what they think." Staff C confirmed that normally residents on these types of medications ([REDACTED]) should be monitored for behaviors.</p> <p>Record review of the MAR (Medication Administration Record) revealed Resident #189 was given [REDACTED] as ordered. Review of the PRN notes stated the resident was given [REDACTED] on multiple occasions for "increased anxiety" and [REDACTED] was given for "increased agitation" but no description of the</p>	F 329	<p style="text-align: right;">IDR AMENDED</p>	

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F 329	Continued From page 54 behaviors observed were present and no target behaviors were identified. Additionally, there was no evidence of non-drug interventions that were tried prior to medications being administered.	F 329		
F 366 SS=D	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE  Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served.  This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to offer food alternatives of similar nutritive value for 3 of 23 resident ( #61, #142, and #106) reviewed in the Stage 2 sample. This failure placed the residents at risk of health complications associated with poor food intake.  Findings Include:  Interview with Staff U revealed kitchen staff prepared and made available at least four choices of entrees of similar nutritive value each meal. RESIDENT #61 On 07/23/13 at 1:00 p.m., Resident #61 was observed in the main dining room with lunch tray sitting in front of him/her. Resident #61 did not eat the food. Resident #61 left the dining room without eating the food. Staff P helped Resident #61 out of the dining room without offering the resident food alternatives.  RESIDENT #142 On 07/29/13 at 5:14 p.m., similar observations	F 366		

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F 366	Continued From page 55 were noted for Resident #142 . Resident #142 was observed not eating the food during dinner time. Asked the Resident how he liked the food served for dinner. Resident #142 stated " I don't really like the food here. The food is not appetizing and does not taste good." On 07/29/13 at 6:20 p.m., observed Resident #92's family member asking Resident #142 if he needed to have something different than what was served for dinner. Resident #92's family member went to the facility kitchen and bought a Turkey sandwich. In an interview on 07/29/13 at 6:30 p.m., Resident #92's family member reported that he/she is frequently in the facility visiting. Over a period of time, he/she has noticed that Resident #142 does not eat his/her food. Resident #92's family member also reported that he/she has not seen facility staff offering food alternatives when the resident does not like what is on tray. Resident #92's family member also indicated frequently having to initiate getting Resident #142 an alternative from the kitchen  RESIDENT #106 Similar observations were noted for Resident #106. On 07/29/13 at 5:35 p.m. Resident #106 was not eating his dinner. The food was noted to be uneaten as the resident left the dining room without being offered food alternatives. In an interview on 07/29/13 at 6:15 p.m., Staff W was asked what he/she does when residents are noted not eating food that they have been served. Staff W stated " Sometimes the residents just take off if they do not like the food. We can not force them to eat if they do not want to eat."	F 366			
F 464 SS=E	483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS	F 464			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505483</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/06/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALASKA GARDENS HEALTH AND REHABILITATION</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>6220 SOUTH ALASKA STREET TACOMA, WA 98408</b>		
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F 464	<p>Continued From page 56</p> <p>The facility must provide one or more rooms designated for resident dining and activities.</p> <p>These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide adequate space for 5 Sample Resident (#s 26, 65, 82, 200 &amp; 204) in 1 of 3 dining rooms (Cascade) to eat comfortably and freely enter and exit when preferred of the 46 residents who were included in the Stage 2 review. This failure placed residents at risk for a diminished quality dining experience.</p> <p>Findings include:</p> <p>All observations and interviews occurred on 7/29/13 during the evening meal.</p> <p>Observation during the evening meal service in the Cascade dining room revealed lack of adequate space. A total of 16 residents in wheelchairs or chairs crowded around six dining tables with additional staff and family members assisting residents to eat. The dining room was approximately 30 feet square with six four-foot square tables arranged in three rows. The number of residents and their seating arrangement limited the space to only 1.5 feet between many seated residents and the width of</p>	F 464	<p style="text-align: right;"><b>IDR AMENDED</b></p>	

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F 464	<p>Continued From page 57 the center aisle.</p> <p>Observation at 5:37 p.m. revealed staff brought Resident #82 in a wheelchair into the Cascade dining hall. Crowding prevented staff from easily moving him to the far side of the table; staff pulled Resident #82 backwards while seated in his wheelchair.</p> <p>At 5:38 p.m. staff moved Resident #200 away from her table and her served food in order to make room in the center isle for Resident #204 to pass through and access another table further back.</p> <p>At 6:00 p.m. staff again moved Resident #200 away from her table and her served food in order to make room in the center aisle to move another resident through to a table in the back.</p> <p>During interview at 6:02 p.m. regarding getting in and out of this dining room, Resident #26 responded he always sat at a table in the back and indicated at times it was difficult to get to his table.</p> <p>At 6:09 p.m. Resident #26 loudly stated that he was ready to leave. He stated he was unable to leave because other wheelchairs were in his way.</p> <p>At 6:11 p.m. staff moved Resident #200 for the third time in order to make room in the center aisle for other residents to leave the dining room.</p> <p>At 6:11 p.m. Resident #26 stated "It doesn't look like we can get through."</p> <p>At 6:12 p.m. staff moved Resident #65 to the other side of his table in order to make room for</p>	F 464		
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F 464	Continued From page 58 other residents to exit the dining room.  At 6:14 p.m. Resident #26 again stated "I can't get through. I can't get through."  At 6:17 p.m. Staff EE stated that normally they don't have to move residents around but confirmed they did during this dining experience.	F 464		
F 497 SS=E	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE  The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.  This REQUIREMENT is not met as evidenced by: Based on Interview and record review, the facility failed to ensure 6 out of 13 Certified Nursing Assistants (Staff CCC, V, JJ, DDD, EEE, and BBB) completed the twelve hours of required continuing education. This failure placed residents at risk to receive inadequate care related to lack of staff knowledge. Findings Include: The following staff did not have the required	F 497	IDR AMENDED	

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F 497	<p>Continued From page 59</p> <p>twelve hours in-service education: Staff CCC hired 6/2/11 did not have evidence of the required annual 12 hours of in-service education requirements. Review of education records for the period of 6/2/12/ to 6/2/13 revealed less than 12 hours completed.</p> <p>Staff V hired 6/14/11 did not have evidence of the required annual 12 hours of in-service education requirements. Review of education records for the period of 6/14/12 to 6/14/13 revealed less than 12 hours completed.</p> <p>Staff JJ hired 4/16/12 did not have evidence of the required annual 12 hours of in-service education requirements. Review of education records for the period of 4/16/12 to 4/16/13 revealed less than 12 hours completed.</p> <p>Staff DDD hired 7/19/11 did not have evidence of the required annual 12 hours of in-service education requirements. Review of education records for the period of 7/19/12 to 7/19/13 revealed less than 12 hours completed.</p> <p>Staff EEE hired 4/12/10 did not have evidence of the required annual 12 hours of in-service education requirements. Review of education records for the period of 4/12/12 to 4/12/13 revealed less than 12 hours completed.</p> <p>Staff BBB hired 5/12/11 did not have evidence of the required annual 12 hours of in-service education requirements. Review of education records for the period of 5/12/12 to 5/12/13 revealed less than 12 hours completed.</p> <p>On 8/5/13 at 4:15 p.m. Staff F stated "The system that we have in place to ensure the staff</p>	F 497	<p style="text-align: right;">IDR AMENDED</p>	
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F 497	<p>Continued From page 60</p> <p>are getting their continuing education hours is very confusing. There are always opportunities for me to teach, if there are any issues that arise...or a staff asks for a particular subject to discuss. At times, the Director of Nursing Services will inform me on what to teach. My supervisor also informs me of what needs to be taught. I just started in April and I do all the teachings and continually look in the book to track the hours. It would be much better in the computer. I ensure that the CNAs are applying the skills by getting feedback from the nurses and by reading the charts."</p> <p>On 8/5/13 at 4:30 p.m., Staff F further explained "I spoke with my supervisor (about CNAs not meeting educational requirement hours) and rather than five minutes of training, it was actually 15 minutes of training."</p> <p>During the interview Staff F observed to change the minutes on the staff's "Individual Inservice Attendance" form to reflect fifteen minutes rather than five minutes of training.</p>	F 497		

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