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

PRINTED: 10/16/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	505183		10/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE HERITAGE REHABILITATION OF TACOMA	7411 PACIFIC AVENUE TACOMA, WA 98408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This report is the result of an unannounced Off-Hours Quality Indicator Survey conducted at Avamere Heritage Rehabilitation of Tacoma on 09/30/13, 10/01/13, 10/02/13, 10/03/13, 10/04/13, and 10/05/13. The survey included data collection on 09/30/13 from 07:00 p.m. to 9:15 p.m. A sample of 31 residents was selected from a census of 59. The sample included 22 current residents and the records of 9 former and/or discharged residents. The survey was conducted by: [redacted] MSW [redacted]n, RN, BSN [redacted] RN, BSN The survey team is from: Department of Social & Health Services Aging & Long Term Support Administration Residential Care Services, District 3, Unit C & D P.O. Box 45819 Tumwater, Washington 98504-5819 Telephone: 360.664.8429 Fax: 360.664.8451 D Longan-Shimer 10/16/13 Residential Care Services Date	F 000	"Heritage Rehab's Plan of Correction shall stand as a written credible assertion of substantial compliance with the Federal and State requirements for skilled nursing facilities participating in the Federal Medicare or applicable State Medicaid programs."Please note that nothing set forth in this document or any other communication in writing or otherwise (including, but not limited to any accompanying exhibits) is to be or should be construed to be and admission by Avamere Heritage Rehab of Tacoma, of the validity or accuracy of any of the deficiencies cited by the SURVEYING ENTITY relative to the survey, certification and enforcement effort at issue. Further, please note that any and all documents transmitted or otherwise provided by Avamere Heritage Rehab of Tacoma in relation to this Plan of Correction, as well as any and all other communicat6ions in writing or otherwise by or on behalf of Avamere Heritage Rehab of Tacoma are and shall be construed to be WITHOUT PREJUDICE to the rights, remedies, claims, defenses of Heritage, at law and/or inequity, all of which are not waived and all of which are reserved and retained by, and for and on behalf of Avamere Heritage Rehab of Tacoma." RECEIVED OCT 28 RCS - REGION	11-8-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Wendy Wheatley — Administrator

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 154 SS=D	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to obtain an informed consent for 1 of 5 current sampled residents (#16) reviewed for unnecessary medications. This failure placed residents and/or legal representatives from being fully informed of the risk and benefits prior to the use of psychotropic medication. Findings include: Resident #16 was admitted to the facility on 08/30/13 with diagnoses including respiratory failure, heart disease, anxiety, chronic pain, depression, kidney disease, diabetes, and arthritis. The resident's Minimum Data Set (MDS), an assessment tool, dated 09/06/13, indicated the resident was able to make needs known, was severely cognitively impaired, required extensive assistance with activities of daily living, and participated in the MDS assessment process.	F 154	Obtained consent for Resident #16. We will complete an audit of other residents with orders for psychoactive medications, and verify consents are in place. We will In-service LNs and Social Services on the appropriate protocol for obtaining an informed consent, prior to the administration of a psychoactive medication. New orders for psychoactive medication will be reviewed in morning meeting to assure that necessary parties are aware and appropriate steps are taken. Psychoactive medications will be reviewed in the Psych Committee meeting and will also be audited quarterly by Social Services and the Resident Care Managers to assure proper consents are in place.	

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F 154	Continued From page 2 The resident's care plan for ineffective coping related to anxiety and depression had interventions including medication and reassurance to resident. On 09/15/13 the physician ordered [redacted] (Pharmacological Category Benzodiazepine; Use Management of Anxiety Disorders or Anxiety Associated with Depressive Symptoms) 0.5 mg (milligrams) q4hrs (every 4 hours) PRN (as needed) - Depression. The Medication Administration Record (MAR) documented 09/15/13 was the first time Resident #16 received the Lorazapam. On 10/04/13 at 11:25 a.m., Licensed Nurse (LN) A stated an informed consent was signed by the resident or the resident's family prior to the administration of a psychotropic medication to inform of them of the risk and benefits of the medication. LN A said there was no consent for the Lorazapam for Resident #16 in the chart.	F 154	Continued from Page 2 Results of audit will be discussed as part of the facility's QAPI (Quality Assurance Performance Improvement) process. The Director of Nursing and/or Designee will be responsible to ensure compliance.	
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These	F 155	Resident #55 and resident #122 were interviewed regarding their preferences on bathing times and schedules. Their care plans and directives were adjusted as indicated. Whole house caring partner rounds were conducted, and residents were interviewed about their preferences with care and daily routines. Adjustments	

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F 155	Continued From page 3 requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. This STANDARD is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to assess the reason for refusing showers or offer alternative options for 2 of 18 current sampled residents (#55 & 122) reviewed for choices. This failure placed residents at risk for unmet hygiene needs and diminished quality of life. Findings include: 1) Resident #55 was admitted to the facility from the hospital on [redacted]13 following surgery for a fractured[redacted] The Minimum Data Set (MDS), an assessment tool, dated 9/2/13, indicated Resident #55 required extensive assistance with activities of daily living including walking, toileting and bathing. The Shower Schedule, dated 10/3/13, indicated Resident #55 was scheduled for showers on Sundays and Wednesdays. The bathing/shower log, dated 9/29/13, stated "Resident refused" a shower.	F 155	were made to the plan of care to accommodate any preferences shared by the residents. Facility will continue caring partner rounds weekly to ensure that any concerns with care are being addressed. Staff will be in serviced on the steps to take when a resident expresses concerns or requests a desired care directive. Results of Caring Partner rounds will be included in the facility's QAPI process. The DNS and Administrator will be responsible to ensure compliance.	

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F 155	Continued From page 4 On 10/2/13 at 10:10 a.m., Resident #55's hair appeared matted and unclean. The resident stated he was supposed to receive a shower twice per week but said "sometimes it gets skipped." Resident #55 reported he was supposed to have a shower on Sunday, 9/29/13. The resident stated, "I said no because I had a dressing change at that time." Resident #55 said no one offered him a shower later that day or an opportunity for a shower before the next scheduled shower on 10/2/13. 2) Resident #122 was admitted to the facility on [redacted]/13 from the hospital. On 10/2/13 at 11:13 a.m., Resident #155's hair appeared matted and unclean. The resident stated, "They never offered me a shower until today. I was already dressed so I said no. If they had offered before I got dressed I would have said yes. They didn't say when they would offer again." Resident #122 was not on the Shower Schedule, dated 10/3/13. On 10/3/13 at 1:30 p.m., the surveyor asked for a copy of Resident #122's bath/shower log and facility staff were unable to provide one. On 10/3/13 at 12:21 p.m., the Director of Nursing Services (DNS) stated the facility attempted to accommodate resident preferences for frequency of showering but there was not a specific policy to assess the reason for shower refusals or to offer an alternative option when a resident refused a shower. When asked, the DNS was not able to	F 155	See Page 3-4	

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F 155	Continued From page 5 provide documentation to verify that residents were assessed for reason for refusing showers or that alternative options were offered when residents refused a shower. On 10/4/13 at 12:18 p.m., Nursing Assistant (NA) B, a shower aide, reported when residents refused a shower she tried to find out why and offer an alternative time if her schedule allowed, and often there was not the time or opportunity to offer an alternative. NA B stated the facility did not have a system for assessing and documenting the reason a resident refused a shower nor was there a policy of offering an alternative.	F 155	See Page 3-4	
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those	F 156	Resident #55 and resident #122 were interviewed regarding their preferences on bathing times and schedules. Their care plans and directives were adjusted as indicated. Whole house caring partner rounds were conducted, and residents were interviewed about their preferences with care and daily routines. Adjustments were made to the plan of care to accommodate any preferences shared by the residents.	

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F 156	Continued From page 6 other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a	F 156	Continued from Page 6 Resident has discharged from the facility. Facility will provide the appropriate liability and appeal notice when patient is discharging from skilled services. The Business Office Manager has been in serviced, on the current requirements and guidelines for issuing liability notices to Medicare patients. Discharges will be reviewed daily at our morning stand up, and the Administrator will resident discharges to ensure that liability notices are issued appropriately. Liability notices issued will be reviewed as part of the facility's QAPI. Facility will continue caring partner rounds weekly to ensure that any concerns with care are being addressed. Staff will be in serviced on the steps to take when a resident expresses concerns or requests a desired care directive.	

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F 156	Continued From page 7 complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide the appropriate liability and appeal notice to 1 of 3 discharged residents (#112) reviewed regarding Medicare beneficiaries. This failure placed residents at risk of not being able to exercise their rights regarding liability and appeal reviews when discharged from skilled services. Findings include: Resident #112 was admitted to the facility on [redacted]/13 with diagnoses including after care from [redacted] fracture and [redacted] fracture. The resident discharged from the facility on [redacted]/13. Record review showed, as a Medicare	F 156	Continued from Page 6-7 Results of Caring Partner rounds will be included in the facility's QAPI process. The DNS and Administrator will be responsible to ensure compliance.	

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F 156	Continued From page 8 beneficiary, Resident #112 did not receive a liability and appeal notice. On 10/04/13 at 11:06 a.m., the Business Manager (BOM) said a liability and appeal notice was not provided to Resident #112. "It is my understanding that as long as they are still skilled and they are choosing to leave (the facility) and they are still skilled, I do not need to give them a notice." At 11:56 a.m., the BOM stated the facility was aware Resident #112 would be leaving the facility two days before the resident left the facility. The BOM said she is now aware a notice should have been provided for the resident, but it was not completed.	F 156	Continued from Page 6-8	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported	F 225	The grievance from resident #12 was converted into an A&I after resident's personal property was not able to be located. The facility followed the protocol for investigation and notification of proper contacts outlined in the purple book. All open grievances were reviewed to ensure timely resolution or conversion to A&I as needed. We will educate staff on the protocol for grievance, and documentation needs.	

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F 225	Continued From page 9 immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to conduct a timely and thorough investigation and report to the state agency in accordance with state law and 42 CFR 483.13(c)(3) an alleged violation to rule out misappropriation of resident property and to protect and prevent further similar incidents for 1 of 18 current sampled residents (#12) reviewed for missing property. This failure to report and conduct a thorough investigation prevented the facility from ruling out misappropriation of the resident's property and placed residents at risk for psychological harm and further misappropriation of resident property. Findings include:	F 225	Continued from Page 9 Unresolved grievances will be discussed at the morning Stand Up meeting until the issue is resolved. Caring Partners will continue to make weekly rounds and staff will follow the grievance policy as issues arise. The grievance log will periodically be reviewed by the Regional Nurse Consultant. The grievances will be reviewed at the facilities Quality Improvement meetings to identify any possible trends. The Administrator will be responsible to ensure compliance.	

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F 225	Continued From page 10 According to the Nursing Home Guidelines (Purple Book), February 2012: Immediate telephone reporting (within 24 hours) to the Department is required for alleged violations, including misappropriation of resident property, or when there is a "reason to suspect" that any crime, including theft, has been committed against a resident of the facility. Misappropriation of Resident Property, as defined in 42 CFR 488.301, means "the deliberate misplacement, exploitation or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent." "'Reason to suspect' has been defined as 'a belief that the incident could possibly have happened' based upon observations and other sources of information," (Purple Book, page 16). Resident #12 was admitted to the facility on [redacted]13 with diagnoses to include a [redacted] disorder. The Minimum Data Set (MDS), an assessment tool, dated 7/30/13, indicated Resident #12 was alert, oriented and able to make herself understood. The resident was non-ambulatory and dependent on facility staff for extensive assistance with nearly all activities of daily living. On 10/01/13 at 4:56 p.m., Resident #12 stated her wedding and engagement ring set were missing. The resident said she was wearing the rings when she went to the hospital for an endoscopy about a week ago, accompanied by Nursing Assistant (NA) A. Resident #12 stated hospital staff said the resident could not wear her rings during the procedure because she would be	F 225	See Page 9-10	

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F 225	Continued From page 11 under anesthesia. Resident #12 reported she gave the 2 rings to NA A at the hospital, just prior to the procedure. When Resident #12 returned to the facility she felt awful and was sick from the medications she received during the procedure. Resident #12 further stated NA A told Resident #12 she put the rings into the resident's fanny pack. Resident #12 stated she told Licensed Nurse (LN) A the rings were missing and said staff looked for the rings. Progress Notes, dated 9/18/13 through 9/20/13, indicated Resident #12 rested in bed after returning to the facility following the endoscopy and experienced nausea for the next 2 days. The Grievance Communication Form statement, dated 9/23/13, written and signed by LN A on behalf of Resident #12, stated, "I gave my wedding ring to [NA A] while I had to have a procedure and she put it in my fanny pack and now I can't find it." On the same grievance form, a statement dated 9/29/13, signed by the Administrator (ADM), reported facility staff assisted Resident #12 in searching for the missing rings in the resident's fanny pack and drawers, and stated the hospital and shuttle service were called, but the rings had not been located. A handwritten statement, signed by NA A, dated 9/23/13, documented that on 9/18/13, at the hospital with Resident #12, NA A put the resident's rings in the resident's fanny pack just before the resident had the endoscopy and put	F 225	See Page 9-10	

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F 225	Continued From page 12 the fanny pack in the hospital "belongings bag." NA A reported that when she and Resident #12 returned to the facility, NA A put the belongings bag on the foot of Resident #12's bed, gave paperwork to the nurse and left the facility for the day. NA A further documented she did not return to the facility until 9/23/13 and stated, "Today when [Resident #12] heard my voice she asked me where I put her ring at and I said in fanny pack. Resident stated it's not there." On 10/4/13 at 10:21 a.m., LN A stated Resident #12 wore the wedding-engagement ring set every day. LN A said that when Resident #12 returned to the facility after the endoscopy, the resident was still groggy and nauseated from the procedure and was not thinking about the rings. LN A stated that on 9/23/13, NA A told LN A that Resident #12 said her rings were missing. Both NA A and LN A looked through the resident's fanny pack and belongings but did not find the rings. LN A further stated she did not write an Incident Report about the missing rings or call the state Complaint Resolution Unit (CRU). LN A filed a facility grievance on the resident's behalf with the understanding it would be reviewed by the ADM, who would develop a plan for how to follow up on the grievance. On 10/4/13 at 9:46 a.m., the ADM stated an Incident Report and full investigation were not initiated in response to Resident #12's missing rings, and the police and the CRU were not called, because the resident did not say the rings were stolen so they were considered a "lost item."	F 225	See Page 9-10	

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F 225	Continued From page 13 On 10/4/13 at 11:29 a.m., Resident #12 stated her wedding-engagement ring set cost $500 which was "a lot of money" and she did not have a lot of money. The resident said she was very sad when she could not find the rings and still felt sad her wedding rings were missing.	F 225	See Page 9-10	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide medically related social services for discharge for 1 of 7 current sampled residents (#12) reviewed for discharge. This failure did not ensure residents would attain their highest practicable physical, mental, and psychosocial well-being. Findings include: Resident #12 was admitted to the facility on [redacted]13 with diagnoses to include a neurological disorder. The Minimum Data Set (MDS), an assessment tool, dated 7/30/13, documented there was an active discharge plan in place for Resident #12 to return to the community and indicated the	F 250	Resident #12 was interviewed and asked us not to actively plan discharge at this time. Care plan has been updated to reflect this. Current resident records will be audited for appropriate discharge planning and ongoing documentation. Appropriate staff will be in serviced on expectations re: documentation of a residents' discharge plan, whether it is self-directed by the resident or facility guided. Social Services will review and document discharge planning a minimum of quarterly.	

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F 250	Continued From page 14 resident was alert, oriented and able to make herself understood. The resident was non-ambulatory and dependent on facility staff for extensive assistance with nearly all activities of daily living. The Care Plan, dated 12/28/12, documented, "Anticipated discharge plan is to return home. Resident lives with a roommate and has a COPES caregiver." Discharge interventions included making arrangements with required community resources to support independence post-discharge. The SS note, dated 2/20/13, indicated a message was left for Resident #12's case manager at the Department of Developmental Disabilities (DDD) stating the resident anticipated discharging to home soon. The SS note, dated 3/13/13, noted the resident would talk to the DDD case manager about housing issues. The SS note, dated 4/16/13, reported staff sent an email message to the DDD case manager regarding money the resident owed her landlord. No other social services documentation was found in Resident #12's record. On 10/01/13 at 4:56 p.m., Resident #12 stated she wanted to discharge to a private residence in the community but there were financial barriers the resident needed assistance with. Resident #12 stated the facility had not provided social services for discharge planning but she did not think it was something the facility was required to provide.	F 250	Continued from page 14 Discharge planning will be audited on a quarterly basis to ensure proper documentation and care plans are in place. Social Services and DNS will be responsible to ensure compliance.	

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F 250	Continued From page 15 On 10/3/13 at 10:38 a.m., the Social Services Director (SSD) stated she was aware Resident #12 was eager to move into a private residence and said the resident was working with DDD about discharge issues. The SSD said normally she would "take the lead" in providing assistance with discharge planning for a resident, but Resident #12 indicated a preference to work directly with her DDD case manager. The SSD did not know who Resident #12's current DDD case manager was or which agencies the resident might be working with to secure housing and other services in the community. When asked, the SSD was unable to provide documentation to verify Resident #12 did not want the facility to assist her in discharge planning.	F 250	See Page 14-15	
F 257 SS=E	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain comfortable and safe temperatures, between 71 and 81 degrees Fahrenheit (F), in 3 of 4 halls, placing residents at risk for loss of body heat.	F 257	Thermostats on the 100, 200 and 400 hallways were adjusted to appropriate temperature, ranging between 71-81 degrees. Temperatures will be maintained in the appropriate range. In-service maintenance director regarding acceptable temperature ranges. In-service staff to report concerns from resident regarding the temperature to Maintenance.	

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F 257	Continued From page 16 This failure placed all residents at risk for decreased comfort and quality of life. Findings included: On 10/1/13 at 4:52 p.m., when asked about problems in the facility that affect comfort, Resident #35 stated, "It has been cold lately." On 10/2/13 at 10:14 a.m., when asked about problems in the facility that affect comfort, Resident #55 stated, "Lately, it's been getting cold." On 10/4/13 at 11:29 a.m., Resident #12 stated it had been cold in the building the past couple days. Thermostat Readings: 10/1/13 on 400 Hall: 66F at 11:00 a.m., 67F at 12:24 p.m., 67F at 5:00 p.m. Throughout the day, wall heaters were noted to be cool to the touch. 10/2/13 on 400 Hall: 66F at 9:35 a.m., 67F at 12:12 p.m., 67F, 66F at 2:37 p.m. 10/2/13 on 100 Hall 70F at 2:40 p.m.; 200 Hall 70F 10/3/13 on tour with Maintenance Director at 13:24 p.m.: 400 Hall 66F, 200 Hall 68F 10/3/13 at 4:30 p.m.: 400 Hall 68F; 200 Hall 70 F; 100 Hall 68 F 10/4/13 at 11:20 a.m.: 400 Hall 67F; 100 Hall 70F On 10/4/13 at 3:45 p.m., the Administrator (ADM)	F 257	Continued from Page 16 We will continue caring partner rounds to ensure that concerns expressed by residents are addressed. Maintenance will monitor ambient temperatures weekly and as needed, and complete appropriate maintenance logs. The Administrator will be responsible to ensure compliance.	

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F 257	Continued From page 17 stated the building temperature should range between 71 and 81F. The ADM stated, "This week has been unusually cold." .	F 257	See Page 16-17	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:	F 278	Resident #66's current assessments were evaluated for accuracy. We will audit all residents for continence and ensure care plan, assessment and MDS are consistent. MDS nurse to communicate and assure MDS' are accurate before submitting. In-service appropriate staff to review assessments for accuracy and consistency. RCM to complete quarterly review to ensure assessments and care plan reflect resident status. Random audits to be conducted by DNS and ADNS The DNS will be responsible to ensure compliance.	

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F 278	Continued From page 18 Based on observation, interview and record review, it was determined the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected 1 of 3 current sampled residents (#66) reviewed for urinary incontinence. Failure to accurately assess residents in a timely manner prevented the facility from identifying, monitoring, treating and/or preventing further urinary continence decline. Findings include: Resident #66 was admitted to the facility on [redacted]13 with diagnoses to include vascular dementia with behavior disturbances. The Minimum Data Set (MDS), an assessment tool, dated 4/12/13, indicated Resident #66 was alert, orient and able to make her needs known. The resident required extensive assistance with bed mobility, transfers, walking and toileting. The MDS indicated the resident was not on a urinary toileting program and was always continent. The MDS, dated 9/7/13, indicated the resident was frequently incontinent of urine. On 10/1/13 at 2:09 p.m., the resident stated, "Occasionally I have waited a half hour. I watch the clock. I have wet the bed a couple times." On 10/3/13 at 11:00 a.m., Nursing Assistant (NA) C stated the resident was able to go to the bathroom independently in May but now was unable to do so. On 10/4/13 at 9:23 a.m., the Rehabilitation Director stated the resident needed minimal staff contact and could use a walker to go to the	F 278	See Page 18	

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F 278	Continued From page 19 bathroom. On 10/4/13 at 11:55 a.m., the MDS Nurse stated the resident's urinary continence decline prohibited Resident #66 from "getting to the toilet in time." The MDS nurse agreed with concerns she overheard the resident's daughter express about staff not toileting the resident in a timely manner to prevent urinary incontinence. On 10/4/13 at 12:30 p.m., the Director of Nursing Services (DNS) provided nursing assistant and restorative aides documentation that indicated the resident was experiencing intermittent incontinence at the time of admission. The DNS stated Resident #66's initial MDS was incorrect and the resident "should have been assessed to have frequent incontinence." Accuracy of the MDS assessment serves as the clinical basis for care planning and care delivery. On 10/7/13 at 5:18 p.m., the DNS stated, "The assessment was completed, just with an error. The error did not affect the resident's care, as the aides were documenting that they had provided incontinent care when applicable."	F 278	See Page 18	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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. A comprehensive care plan must be developed	F 280	Resident #16's Care Plan and Kardex were updated immediately to reflect current interventions that were in place.	

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F 280	Continued From page 20 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to revise the care plan related to resident safety after a fall for 1 of 3 current sampled residents (#16) reviewed for accidents. This failure placed residents at risk for not receiving appropriate care. Findings include: Resident #16 was admitted to the facility on [redacted]/13 with diagnoses including respiratory failure, heart disease, anxiety, chronic pain, irritable bowel syndrome[redacted] hypertension, chronic airway obstruction, kidney disease, diabetes, osteoarthritis, and rheumatoid arthritis. The resident's Minimum Data Set (MDS), dated 09/06/13, indicated the resident was able to make needs known, was severely cognitively impaired, required extensive assistance with activities of daily living, and participated in the MDS assessment.	F 280	Continued Page 20 An audit of A&I's for any falls over the for the last 90 days will be completed to ensure that interventions put in place for residents as a result of these incidents have been care planned appropriately. Care plans will be reviewed quarterly to assure that appropriate interventions are in place Active A&Is will be reviewed at morning Stand Up meeting to ensure that appropriate interventions are being put in place, and care planned accordingly. The DNS will be responsible to ensure compliance.	

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F 280	Continued From page 21 The resident's Fall Risk Evaluation, dated 08/30/13, documented the resident had a moderate risk for falling. On 10/01/13 at 12:52 p.m., Licensed Nurse (LN) A stated on 09/23/13 Resident #16 had a non-injury unwitnessed fall while trying to ambulate to the bathroom. Accident/Incident Log documented the resident had a fall on 09/23/13. The investigation documented the resident was trying to self-toilet and sat down on the floor. "On this occasion the resident was found on the floor by her sink. According to resident she was trying to use the bathroom, resident usually is w/c (wheelchair) bound and has required total assist with toileting as she has been incontinent. Resident has been working with therapy and they have been ambulating resident and she has been having gains in strengthing. Resident cognitive status has been improving and she is beginning to recognize the need to use the bathroom. Resident had no injury related to fall and was educated on asking staff for assist to the bathroom as she has not been cleared to be indep. (independent). Resident bed also placed in low position to decrease chance of injury as resident still has issues with safety awareness. Neuro (neurological checks) were initiated and remained wnl (within normal limits). Careplan updated." Record review showed the resident's care plan for Moderate Risk for Falls documented an actual fall on 09/23/13 and included an intervention to educate the resident/family about safety reminders. The care plan did not include an	F 280	See Page 20-21	

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F 280	Continued From page 22 intervention of a low bed for the resident. On 10/04/13 at 11:00 a.m., LN A stated Resident #16's care plan and care directives had not been updated after the resident's fall on 09/23/13. Updating the care plan and care directive would have provided caregivers with instruction to place the resident's bed in the low position to decrease the chance of injury if there was a fall.	F 280	See Page 20-21	