

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

PRINTED: 02/14/2013
FORM APPROVED
OMB NO. 0938-0391

1405

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/31/2013
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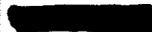
NAME OF PROVIDER OR SUPPLIER AVAMERE SKILLED NURSING OF TACOMA	STREET ADDRESS, CITY, STATE, ZIP CODE 3625 EAST B STREET TACOMA, WA 98404
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F 000 INITIAL COMMENTS

This report is the result of an unannounced Quality Indicator Survey conducted at Avamere Skilled Nursing of Tacoma on 01/22/13, 01/23/13, 01/24/13, 01/25/13, 01/28/13, 01/29/13, 01/30/13 and 01/31/13. A sample of 32 residents was selected from a census of 71. The sample included 27 current residents, the records of 3 former and/or discharged residents and 2 supplemental residents.

Survey team members included:

 MSW
 RN, MN
 RN, MN

The survey team is from:
Department of Social and Health Services
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Telephone: (253) 234-6000
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Residential Care Services
2-14-13
Date

F 000

"Avamere Skilled Nursing of Tacoma'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 Skilled Nursing 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 Skilled Nursing of Tacoma in relation to this Plan of Correction, as well as any and all other communications in writing or otherwise by or on behalf of Avamere Skilled Nursing of Tacoma are and shall be construed to be WITHOUT PREJUDICE to the rights, remedies, claims, defenses of Avamere Skilled Nursing of Tacoma, 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 Skilled Nursing of Tacoma.

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MAR 05 2013

DSHS/ADSA/RCS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADM.	(X6) DATE 3-4-13
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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 156 SS=D	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>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.</p> <p>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 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.</p> <p>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.</p> <p>The facility must furnish a written description of legal rights which includes:</p>	F 156	<p><u>F 156</u></p> <p>Resident #2 is no longer in the facility.</p> <p>Facility will provide residents with written liability notices when status changes and no longer meets Medicare criteria. Additionally, the CMS form 1055 ABN will be provided to residents coming off skilled Medicare services.</p> <p>Staff will be re-educated on guidelines when notices are to be presented and to obtain acknowledgement of delivery.</p> <p>Residents will be reviewed during regular Medicare meeting, determine date to be delivered if necessary.</p> <p>Audit of notices for three months will be completed and reviewed</p>	3-27-13 007

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F 156	Continued From page 2 A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must 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 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	F 156	with facility Quality Assurance Committee (QA); and randomly thereafter. Date corrective action will be complete is March 27, 2013 Administrator to assure compliance.		

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F 156	<p>Continued From page 3</p> <p>policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review the facility failed to provide liability notices for one (#2) of three residents reviewed for liability notices. Failure to do so placed the residents at risk for not being fully informed of and/or understanding their Medicare benefits.</p> <p>Findings include:</p> <p>Record review revealed Resident #2 received Medicare Part A services. These services ended on 10/12/12. In an interview on 01/28/13 at 2:15 p.m. Staff E said the resident remained in the facility on Medicaid after the Medicare services ended and then transitioned to hospice. Review of the Notice of Medicare Non-Coverage, dated 10/10/12, revealed the notification did not include a signature of the patient or representative. Handwritten was "Spoke with mom... regarding</p>	F 156			

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F 156	Continued From page 4 upcoming (Medicare) denial due to not meeting criteria. Acknowledges pay change, effective 10/13/12, and requested letter be kept in facility to be picked up by her vs. being mailed out." Staff E said she spoke with Resident #2's representative and left the notice in the resident's room for her to sign and return. Staff E said she did not mail the notice or follow up to ensure Resident #2's representative received the form, nor did she obtain a signature. In addition, the facility failed to give the Resident's representative an additionally required form to ensure the resident had the option to continue services that would not be covered by Medicare (CMS form 1055 SNF ABN). In an interview on 01/28/13 at 3:36 p.m. Staff E said she mistakenly thought the additional form was only issued if the resident choose to appeal the decision.	F 156		
F 159 SS=D	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal	F 159	<u>F 159</u> Resident #114's refund check was originally written on 8/30/12. Check did not clear in 90 days so check was re-issued on 1/28/13. Check was incorrectly written to the State Unclaimed Property. Unclaimed Property has been contacted and is refunding this to the resident.	3-27-13 001

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F 159	<p>Continued From page 5</p> <p>funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review the facility failed to ensure resident's personal funds were returned to them within 90 days of discharge, according to facility protocol. This failure resulted in residents having significant delays in receiving</p>	F 159	<p>Resident 115 was refunded on 11/8/12. Resident is no longer in the facility.</p> <p>Residents #29, 54, and 30 have been informed of policy on how to access personal funds on weekends and after business hours. Policy has been reviewed with Resident Council and letter has been provided to those with a Trust Account.</p> <p>An audit of discharged residents with a Trust account for personal funds has been completed. Trust will be reviewed monthly against discharges to validate money has been refunded timely.</p> <p>Results will be presented to the QA committee for 3 months and then periodically thereafter.</p> <p>Business office staff will be re-educated related to the policy on returning resident personal funds after discharge.</p>	

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F 159	<p>Continued From page 6</p> <p>funds owed them. Additionally, the facility failed to ensure five of 27 sampled residents (#s 29, 54, 30, 114, 115) were aware of how to access and obtain personal funds on the weekends or after business hours.</p> <p>Findings include:</p> <p>TRUST FUND RECONCILIATION In an interview on 01/31/13, Staff N and the Corporate Financial consultant indicated it was their policy and practice to disperse resident funds "within 90 days of discharge." These staff further explained it was their practice to assess their records monthly to ensure accuracy and timely disbursement of funds.</p> <p>According to the Resident Trust Reconciliation (RTR) dated December 2012, Resident #114 had a check issued on 08/30/12, the date of discharge, for \$71.72. According to an interview with Staff N (Business Office Manager) and the Financial Consultant (FC) on the morning of 01/31/13, the resident discharged from the facility on 08/30/12. A notation dated 08/30/12 indicated the check was lost and reissued. Staff N stated, the resident was called to find out why the check wasn't cashed and then a check was reissued. Staff N was unable to indicate when the check was reissued. Staff N reported the check was reissued "this month" and the check was "accidentally sent to OFR (Office of Financial Recovery)" instead of the resident which resulted in a five month delay in the resident receiving funds.</p> <p>According to the RTR, Resident #115 was</p>	F 159	<p>After hours policy will be posted for residents.</p> <p>After hours access will be monitored through the reconciliation of the account and random resident interviews.</p> <p>Results will be reviewed in QA for three months and randomly thereafter.</p> <p>Date corrective action will be complete is March 27, 2013</p> <p>Responsible person: Administrator</p>	

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F 159	<p>Continued From page 7</p> <p>discharged on 07/17/12 but his funds were not disbursed until 11/08/12, more than 90 days after discharge. According to the consultant financial staff, "he was missed".</p> <p>ACCESS TO RESIDENT FUNDS</p> <p>In an interview on 01/23/13 at 9:16 a.m., Resident #29 indicated he did not have access to his money when he needed it stating, "I think you can get it up to noon (on the weekends)."</p> <p>Resident #54, in an interview on 01/23/13 at 10:00 a.m. stated, "It's (the business office) open Monday through Friday, late, but not on the weekends."</p> <p>Resident #30, in an interview on 01/24/13 at 9:20 a.m., stated, "I've had problems on the weekend getting money. You can go to the front desk until 1:00 p.m. on the weekend, if you want money, after that, tough."</p> <p>In an interview on 01/31/13 at 8:20 a.m., Staff N indicated resident funds were available on the weekend at the Business Office (BO) from 9:30 a.m. until 1:00 p.m. and after that residents could access their money from the Nurses Station on the 100 unit.</p> <p>When asked how residents would know this, Staff N indicated there was a sign posted outside the BO which informed residents how to access their money after the BO closed. When asked, Staff N was unable to locate any signage notifying residents how to access their funds after BO hours.</p>	F 159		
F 241	483.15(a) DIGNITY AND RESPECT OF	F 241	<u>F 241</u>	3-27-13 011

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F 241 SS=E	<p>Continued From page 8 INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to provide care and services in a manner that promoted and protected resident dignity and individuality for one of seven Residents (#5).</p> <p>The facility failed to ensure pet names were used only when indicated by resident preference for two of seven Resident (#s 51 and 57). In addition, using labels to refer to residents who required assistance placed residents at risk to not feel respected as individuals.</p> <p>The facility failed to ensure staff knocked and announced staff presence before entering resident's rooms detracted from a resident's sense of security and control over their environment for two of seven Residents (#s 6 & #20).</p> <p>The facility failed to ensure clothing items were labeled in a manner that promoted dignity for four of seven residents (#s 40, 60, 75 & 90) residents observed. Prominently writing resident names on clothing items in a visible manner detracted from residents sense of dignity and fostered a sense of institutionalization.</p>	F 241	<p>Facility provided an escort to accompany resident #5 to the locker unit on 2/14, 2/15 and 2/27/2013. Resident is fully responsible for the unit, and on one occasion did not take his key. Another occasion took the wrong keys, so on 2 trips was not able to access the unit. A new lock and key were arranged for, by provider, so resident could access the unit. Provider does not have nor should have a copy of key to the unit.</p> <p>Social Services have met with resident to assure there is no psychological harm and that there was no intent of retaliation.</p> <p>Interviews were completed with resident#51 to see what name they preferred to be called. Resident #57's guardian has been contacted to verify name resident</p>	
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F 241	<p>Continued From page 9</p> <p>Findings include:</p> <p>ASSISTANCE RESIDENT #5 According to the Minimum Data Set (MDS) dated 12/16/12, the resident had diagnoses of [REDACTED]. The resident had an extensive history of [REDACTED] problems including [REDACTED] and [REDACTED] aggression. In an interview on 01/23/13 at 4:07 p.m., Resident #5 stated he felt staff did not treat him with dignity and respect. The resident explained he had been discharged to the hospital and "the last administrator moved most of my property into a storage locker." "He boxed my stuff up when I was in the hospital." The resident elaborated the storage unit cost him "\$61 a month", which he was required to pay. The resident indicated he wanted to bring his belongings to the facility. He explained, "the interim Administrator was going to let a staff member help me go through my things. She said ok but then was fired before it happened. Last Wednesday or Thursday I spoke to the new Administrator and he said he would honor her wishes. He scheduled it for 01/22 and 01/23 from 10:00 a.m. until 1:00 p.m." The resident went on to explain there was an incident on 01/20/13 with a Certified Nursing Assistant (CNA), Staff PP. He stated she attempted to help him but did not know how to do so appropriately. I got frustrated and said "God dammit". The next day the Administrator said he wouldn't let anyone go with me and that since I was fixing to discharge I could just handle it when I left." The resident felt retaliated against. There was no documentation to support the facility followed up</p>	F 241	<p>prefers to be called. If residents unable to indicate contact appropriate responsible party to identify. Update care plan to include preference. If no one can answer the question, staff will be educated to call by name.</p> <p>Social Services met with resident #6 and #20 about staff failure to knock and wait for permission prior to entering the resident's room.</p> <p>Resident # 40 will be provided appropriately fitting garments to promote dignity.</p> <p>Residents #60, 75, and 90 have had clothing items identified inappropriately labeled. Families have been contacted to replace and labeled in a manner to promote dignity.</p> <p>Residents will be interviewed during Caring Partner rounds to determine name preference. Care</p>	

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F 241	<p>Continued From page 10 with the resident's concern.</p> <p>PET NAMES RESIDENT #57 & #51 According to the 10/30/12 MDS, Resident #57 had a diagnosis of [REDACTED] and was assessed to communicate with [REDACTED] words and was rarely/never understood.</p> <p>Observation on the 400 unit at 12:30 p.m. on 01/29/13 revealed housekeeping and CNA staff passing trays to residents. Housekeeping and CNA staff were noted to call Resident #57 "Grandma". Staff stated, "Where you going Grandma?" and "It's time for lunch Grandma."</p> <p>In an attempted interview at that time, the resident was unable to indicate if it was acceptable for staff to call her "Grandma". Similar observations were noted for Resident #51 on 01/24/13 at 9:35 a.m. when Staff VV stated, "Here's your call light Papa." Use of pet names in the absence of documentation to support resident preference had the potential to diminish one's sense of dignity.</p> <p>On 01/22/13 at 12:15 p.m. a contracted staff was observed to propel a resident toward the dining room. A nurse overheard the surveyor question where they were going and called down the hall, "The feeders eat in the dining room."</p> <p>STAFF FAILURE TO KNOCK Residents #6 & #20 During an interview on 01/24/13 at 8:30 a.m. with Resident #6, a staff member knocked on the door and immediately entered the room without waiting</p>	F 241	<p>plans will be updated with the results, if different than their given name.</p> <p>Upon admission, residents will be asked name they want to be called.</p> <p>Residents have been reminded of the grievance procedure, should they feel staff is entering their room without permission. Will also review with Resident Council, in order to keep residents aware of the facility procedure.</p> <p>Staff will be re-educated on keeping residents completely covered and clothed in route to their baths.</p> <p>Laundry staff will be reviewing residents clothes for being appropriately labeled, will remove any clothing items labeled in manner to deny resident dignity. Families will be contacted and asked to remove and / or replace.</p>	
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NAME OF PROVIDER OR SUPPLIER AVAMERE SKILLED NURSING OF TACOMA			STREET ADDRESS, CITY, STATE, ZIP CODE 3625 EAST B STREET TACOMA, WA 98404	
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F 241	<p>Continued From page 11</p> <p>for a response. She then saw the surveyor and said, "Oh, sorry, I'll come back later with the menu." Resident #6 stated, "They think they can walk in like a bull. No respect for anyone. How do they expect us to have respect for them if they don't show it?" She stated staff frequently entered her room without knocking, or would knock as they entered without waiting for a response.</p> <p>During an interview on 01/28/13 at 8:57 a.m. with Resident #20 in her room, Staff WW walked into the resident's room without knocking. She stated, "I just need to pick up your tray." Resident #20 stated, "They do it all the time." Staff WW was then observed to walk into another room on the hall at 8:59 a.m. without knocking.</p> <p>UNDIGNIFIED DRESS On 01/28/13 at 9:33 a.m. Resident #40 was observed seated in hallway 300 with other residents wearing only a blue bathrobe snapped close. The resident was not wearing undergarments and her private parts could easily be seen between the snaps from across the hall. In addition, the resident had on no socks or shoes. According to Staff KK, Resident #40 was "waiting for a shower." When asked how long she had been in that position, Staff KK responded, "Not very long, about 15 minutes."</p> <p>Observation on the late morning of 01/22/13 revealed Resident #60 in a sweatshirt. His first name was written across the back in black marker. When asked about the label, he stated, "How should I know what's on my back?"</p>	F 241	<p>Staff will be reeducated regarding providing care and services that promotes residents dignity and individuality that includes:</p> <p>Using appropriate names as indicated on care plan and not to refer to residents using labels</p> <p>Knocking on residents doors, waiting for a response, before entering</p> <p>Appropriate labeling technique and location on clothing. (Family to be included).</p> <p>Providing appropriate clothing to cover residents when in route to their baths.</p> <p>Will be monitored through Caring Partners Rounds, resident interviews and discussion with Resident Council. Grievances will be reviewed to determine resident utilization and satisfaction.</p>	

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F 241	<p>Continued From page 12</p> <p>Observation on 01/23/13 at 12:36 p.m. revealed Resident #75 lying in bed watching television. The resident was noted to have his name written on the front of his shirt in black marker.</p> <p>On 01/24/13 at 8:23 a.m., Resident #90 was observed in the dining room eating breakfast. His first initial and full last name were written in black ink across the back of his shirt.</p> <p>Prominently displaying a resident's name on clothing failed to promote an environment of dignity and a lack of institutionalization.</p>	F 241	<p>Results will be reviewed in facility QA meeting for 3 months and periodically thereafter.</p> <p>Date corrective action will be complete is March 27, 2013</p> <p>Social Services to monitor compliance, Director of Nursing responsible for compliance.</p>	
F 250 SS=E	<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:</p> <p>Based on observation, interview and record review the facility failed to: Through the assessment and care planning process, identify reasons for refusals and seek ways to support residents' individual needs, preferences, concerns and choices for six of 27 sampled Residents (#s 5, 52, 54, 79, 18 & 47) reviewed; Find options that most meet the physical and emotional needs of each resident; Provide alternatives to drug therapy or restraints by understanding and communicating to staff why</p>	F 250	<p><u>F 250</u></p> <p>Social services have meet with resident #5 in an attempt to identify concerns and reasons that trigger his behavior. The Interdisciplinary team has reviewed and updated the plan of care, behavior intervention record with individualized interventions.</p> <p>Social services have met with resident #54 in an attempt to identify root cause of resident refusals and explore options to reflect the resident's needs. The Interdisciplinary team reviewed resident and plan of care and</p>	3-27-13 DL

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F 250 Continued From page 13
residents act as they do, what they are attempting to communicate, and what needs the staff must meet for Resident #5.

Findings include:

RESIDENT #5

Resident #5 had diagnoses of [REDACTED]. The resident had an extensive history of [REDACTED] problems including [REDACTED] and [REDACTED] aggression.

In an interview on 01/23/13 at 4:07 p.m., Resident #5 stated he had been discharged to the hospital and "the last administrator moved most of my property into a storage locker." "He boxed my stuff up when I was in the hospital." The resident elaborated the storage unit cost him "\$61 a month", which he was required to pay. The resident indicated he wanted to bring his belongings to the facility. He explained, "the interim Administrator was going to let a staff member help me go through my things. She said ok but then was fired before it happened. Last Wednesday or Thursday I spoke to the new Administrator and he said he would honor her wishes. He scheduled it for 01/22 and 01/23 from 10:00 a.m. until 1:00 p.m."

The resident went on to explain there was an incident on 01/20/13 with a Certified Nursing Assistant (CNA), Staff PP. He stated she attempted to help him but did not know how to do so appropriately. I got frustrated and said "God dammit".

The next day the Administrator said he wouldn't let anyone go with me and that since I was fixing to discharge I could just handle it when I left."

F 250

behavior intervention flow sheet will be updated to reflect individualized interventions.

Social services to meet with resident #79 with an interpreter to identify root cause of refusals of dental care and establish a plan to meet residents dental needs.

Social services to meet with resident #52 in an attempt to identify root cause of refusals of dental care and establish a plan to meet residents dental needs.

Social services will meet with resident #18 in an attempt to identify concerns and reasons that trigger behaviors. The interdisciplinary team has reviewed the resident and updated the plan of care and behavior intervention flow sheet with individualized interventions.

Social services to meet with resident #47 in an attempt to identify root cause of refusals of medication to support the

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F 250	<p>Continued From page 14</p> <p>The resident felt retaliated against. There was no documentation to support the facility followed up with the resident's concern.</p> <p>Although the resident demonstrated frequent inappropriate verbally aggressive behavior, the the facility failed to identify the reasons why the resident demonstrated this frustration in anger and agitation as it related to his perception of staff not meeting his needs. There was no documentation to support the resident received social services to address his concerns or that interventions were implemented, evaluated for effectiveness and revised according to the resident's needs.</p> <p>RESIDENT #54 According to the 11/24/12 Minimum Data Set (MDS), Resident #54 was assessed to have rejection of care on one to three of the past seven days.</p> <p>According to CPs dated 11/10/12, the resident was identified with "██████████" in which resident acts characterized by inappropriate behavior: Resistive to treatment/care and showers related to change in mental status, confusion and diagnosis of depression." Goals included, "resident will accept care every shift." A nutritional CP indicated the resident demonstrated, "refusal of weights".</p> <p>In an interview on 01/30/13 at 10:20 a.m., the resident stated he had not refused to get out of bed, "I used to get up, I've been up a few times, it's just been a while". The resident elaborated,</p>	F 250	<p>residents individual needs, preferences, and choices regarding medication administration. The resident's plan of care and behavior intervention flow sheet will be updated to reflect the resident's individual interventions.</p> <p>Social services has interviewed residents that are identified as refusing care and/or services in an attempt to establish the root cause of refusals and explore individualized options to meet the residents needs. The residents' plan of care and behavior intervention flow sheet will be updated to reflect the resident's individual interventions.</p> <p>Social services have interviewed residents that have displayed frequent inappropriate, verbally inappropriate behavior to identify concerns and reasons that trigger behavior. The Interdisciplinarnay team has reviewed the residents and updated the plan of care and</p>	
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F 250	<p>Continued From page 15</p> <p>"It's just once they get you up, you can't get em to get you back down, it takes hours, I can't be up for four hours."</p> <p>According to a Care Area Assessment dated 09/02/12, "Resident refused to have bowel movement until had bariatric Bed Side Commode." In an interview on 01/30/13 the resident indicated he wasn't aware he could refuse to have a bowel movement, but "sitting up sure does make it easier."</p> <p>According to a 01/30/13 statement, Staff J . documented Resident t#54 refused his restorative program on multiple days in January 2013. There was no documentation to support facility staff attempted to determine why the resident refused or find options that might meet the resident's needs.</p> <p>There was no documentation to support the facility attempted to determine the root cause of the resident refusing care and services. This placed the resident at risk for not having care needs met.</p> <p>RESIDENT # 79 & #52</p> <p>Dental consult forms dated 09/19/12 indicated the resident had, "gums which were "red/irritated," "has bleeding gums upon palpitation", "Heavy (wall to wall) plaque & calculus", decayed teeth "which need attention" and "broken teeth or root tip". The dental staff noted the resident "doesn't speak English" and the doctor recommended "hygiene cleaning".</p> <p>According to dental consult documents dated 12/21/12, "the resident refused dental</p>	F 250	<p>behavior intervention flow sheets with individualized interventions.</p> <p>Social services and nursing staffs will receive education regarding the facilities behavior management program to include, root cause analysis, identifying triggers for inappropriate verbal aggressive behavior and implementation of individualized interventions based on resident specific needs.</p> <p>Re-educate social services and nursing on how to develop behavior management flow sheets, with appropriate target behaviors and individualized interventions.</p> <p>The residents Behavior Intervention flow sheets, alert charting and 24 hour report will be reviewed by the Interdisciplinary team to identify new behaviors or an increase in behaviors and the appropriate interventions to be implemented.</p>	

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F 250	<p>Continued From page 16</p> <p>prophylaxis, (Doctor) aware no new orders." There was no indication facility staff attempted to determine why the resident refused or how they might meet her dental needs in the future.</p> <p>Similar findings were identified for Resident #52 for whom staff identified dental refusals. In an interview on 01/30/13 at 3:04 p.m. Staff H (Social Services), "I don't know why he refused but I have the documentation he refused."</p> <p>RESIDENT #18 According to the 10/23/12 Annual MDS the resident had diagnoses including [REDACTED] for which he received daily [REDACTED] and [REDACTED] medications. The resident exhibited no rejection of care and no behavior symptoms.</p> <p>According to the 01/10/13 quarterly MDS the resident exhibited no physical behavior toward others and no verbal behavior toward others. The MDS identified the resident exhibited other behaviors ie throwing, verbal symptoms on one to three days which did not significantly interfere with the resident's care. In addition the resident exhibited rejection of care on one to three days.</p> <p>Review of the resident's care plan revealed a 10/31/12 "Problematic behavior CP in which resident acts characterized by ineffective coping: Verbal aggression yelling at staff" and a 10/30/12 "Problematic manner CP in which resident acts characterized by ineffective coping: Physical Aggression, history of throwing items at staff, Resident has ineffective coping skills."</p>	F 250	<p>Results will be reviewed in facility QA meeting for 3 months and periodically thereafter.</p> <p>Date corrective action will be complete is March 27, 2013.</p> <p>Social Services to monitor compliance, Director of Nursing responsible for compliance.</p>	
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F 250 Continued From page 17
A 10/25/12 Psychotropic Medication Review and Physician Communication Form indicated the resident had "Angry outburst" twice in the prior month, and "Confabulation" once in the prior month. The team review commented the resident "has had multiple angry outbursts. Occasionally responds to redirection but only temporarily."

Review of the January 2013 Behavior Intervention Monthly Flow Sheets revealed the target behaviors were triggered by "waiting for call light."

In an interview on 01/29/13 at 9:49 a.m. Staff I said waiting for the call light "was one of the typical triggers." When asked if the resident's behavior could be reasonably related to the lack of staff response, Staff I replied, "It could be, but not every time. It would depend on the situation. He has angry outbursts regardless of call lights. A little thing will set him off."

The facility failed to consider the resident's behaviors were exhibited as a response to actions of staff and provide appropriate interventions to manage his behaviors and improve his well-being.

RESIDENT #47
According to the 01/09/12 MDS, Resident #47 had a [REDACTED] that indicated [REDACTED]. The resident rejected care on four to six days, but less than daily. The resident was assessed to require one person extensive assistance to eat and total dependence of one person to bathe.

The 01/14/13 Inappropriate Behavior CP

F 250

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F 250	<p>Continued From page 18</p> <p>identified the resident as "resistive to treatment/care, refuses medications at times. The listed goal was "will accept medication, treatment or procedure". The interventions were as follows: If resident resists with ADL/Care, leave resident safe & return a few minutes later, initiate conversation before attempting ADL and provide flexibility in ADL routine to accommodate residents mood.</p> <p>Review of Resident #47's Medication Administration Record revealed she periodically refused medication since September 2012, with increasing frequency through January 2013.</p> <p>A 12/12/12 Social service note revealed "resident has a slight decline in mood throughout the past quarter. MHE requested due to residents request and refusal of medications. Care plan has been updated... will continue to monitor mood and behavior."</p> <p>A 12/14/12 [REDACTED] medication review and physician communication form indicated the team identified the "Increase in behaviors ie refusal of care et meds." Their recommendation was to "Await MH eval Recs, (follow up) in 6 weeks." A 12/27/12 Psychiatry note did not address the reasons for the resident's refusals and noted "pleasant but complains of [REDACTED] mood, add [REDACTED] daily, monitor mood and liver function." The facility implemented the recommendation to increase medications, rather than determine the reason for the resident's refusals and attempt to implement a plan which would ensure she took the medications already ordered.</p> <p>On 01/09/13 a Physician's Order was obtained to</p>	F 250		

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F 250	<p>Continued From page 19</p> <p>notify the MD of medication refusals only once a week due to the frequency of refusals.</p> <p>According to a 12/24/12 Resident Concern Report, Resident #47 said she was upset with a nurse the other night "regarding her medications and how they were given." In an interview on 01/30/13 at 2:46 p.m. Staff B said recalled on the night in question the resident wanted her medication with pudding or applesauce and the LN didn't have what she wanted. The LN offered the alternative, which the resident refused.</p> <p>In an interview on 01/28/13 at 2:41 p.m. Staff B said she had met with Resident #47 regarding the refusal of her meds, but only in regard to the [REDACTED]. Staff B said Resident #47 said she "was no longer depressed and didn't want it."</p> <p>In an interview on 01/29/13 at 9:49 a.m. Staff I said she met with Resident #47 and when asked why she was refusing medications, Resident #47 said she wanted to take them with breakfast. Resident #47 said she did not want to take medications while in bed and she wanted to eat food so she was not taking medications on an empty stomach. Staff I said she relayed the information to Staff C.</p> <p>In an interview on 01/30/13 at 8:46 a.m. Staff C said Social Services relayed the conversation just before the resident left the building (01/24/13) and she did not update the care plan without the resident in the facility.</p> <p>The facility failed to provide social services in order to identify and seek ways to support the resident's individual needs and preferences,</p>	F 250		

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F 250	Continued From page 20 customary routines, concerns and choices regarding medication administration.	F 250		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop and/or revise comprehensive care plans for seven of 27 sample residents (#s 79, 54, 20, 18, 82, 47 & 3). Failure to establish care plans that accurately reflected assessed care needs and provide direction to staff on the residents' care related to	F 279	F 279 Resident #79 and 54's infections have resolved. Resident #20 has been evaluated by physical therapy and the therapy recommendations have been discussed with resident. Resident's ADL self care performance deficit care plan has been updated. Also, resident's antidepressant care plan has been updated. Resident #18 has been discharged. Clarified resident #82's Trazadone order. Care plan has been updated to include appropriate diagnosis, resident goals related to sleep, and non pharmacological interventions to promote sleep.	3-27-13 DM

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F 279	<p>Continued From page 21</p> <p>infections, activities of daily living, psychotropic medications, nutrition, fall precautions, positioning, and catheter use placed residents at risk to receive less than adequate care.</p> <p>Findings include:</p> <p>RESIDENT #79 & #54 Observation on 01/23/13 revealed a sign on the resident's door which read, "see nurse before entering". Two linen barrels and a plastic cart containing Personal Protective Equipment were located inside the door.</p> <p>Review of electronic records revealed the resident was being treated for an identified infection, however, there was no evidence of a Care Plan (CP) which reflected the resident had a potentially contagious infection or instructions to staff regarding what precautions to take.</p> <p>In an interview on 01/28/13, Staff O indicated Resident #79 was on contact precautions for an [REDACTED] and the nurse taking the order to treat the [REDACTED] should develop the CP. Staff E, on 01/28/13, confirmed the absence of a CP regarding contact precautions. Similar findings were identified for Resident #54, who was identified with an infection which required contact precautions and no CP was developed.</p> <p>RESIDENT #20 Review of Resident #20's record revealed an ADL Self Care Performance Deficit care plan. Identified goals included the resident will "increase her level of mobility by transferring from the bed to/from her wheelchair with a slide board, being independent with wheelchair propulsion,</p>	F 279	<p>Resident #47 's electric tilt and space wheelchair has been repaired. Social Services (SS) has interviewed resident to establish root cause of refusals and care plan has been updated.</p> <p>Resident #3 has had care plan updated to reflect current hospice status.</p> <p>Care plans updated for residents identified with current infection or treatment using antibiotics.</p> <p>Residents with tilt and space wheelchairs will be evaluated for proper functioning.</p> <p>Residents who receive Trazadone have been reviewed for appropriate diagnosis and care plans have been updated with resident's goals and nonpharmacological interventions to promote sleep.</p> <p>Residents who receive antidepressants have been reviewed for appropriate</p>

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F 279	<p>Continued From page 22 and demonstrating bed bath with set up". Interventions included the assistance the resident currently required, including transfers with a mechanical lift and directions to staff to approach the resident slowly and allow time for the resident to process information. The CP did not include specific steps which the resident should take in order to meet these goals.</p> <p>In addition, the Anti-depressant medication CP identified Resident #20 received [REDACTED], however review of her POs revealed she received [REDACTED] and not [REDACTED]</p> <p>RESIDENT #18 & # 82 According to the 10/23/12 annual MDS, Resident #18 required two person extensive physical assistance with bed mobility and received no turning/repositioning program. In the resident mood interview the resident indicated he had trouble falling or staying asleep and felt tired or had little energy nearly every day.</p> <p>The 11/05/12 ADL Self Care Performance Deficit and limited mobility CP Interventions indicated the resident required 1-2 person extensive assist to turn and reposition. A 01/14/13 Alteration in skin integrity Temporary CP included the intervention, "Remind and encourage resident to reposition often to promote skin integrity."</p> <p>Throughout the survey Resident #18 was observed in bed, lying on his back, with a [REDACTED] in place. In an interview on 01/22/13 at 12:11 p.m. the resident was asked if staff turned him and he replied "No. I scooted up some and</p>	F 279	<p>diagnosis and care plans have been updated with resident's goals and interventions.</p> <p>Residents receiving hospice services have had care plans updated to include appropriate diagnosis and current status.</p> <p>Residents have been evaluated for the necessity of a turning and repositioning program and care plan updated to reflect residents' assistance level and care needs.</p> <p>Interviewed residents identified for refusing to turn and reposition, established root cause, and developed resident driven care plan.</p> <p>Re-educated nursing on procedures to take when new infections occurs to include physician orders, implementing precautions, and creating comprehensive care plans.</p>	

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F 279	<p>Continued From page 23 down. I did sit ups, and pilates and isometrics."</p> <p>In an interview on 01/31/13 at 11:00 a.m. Staff C said "He does raise his head of bed, we encourage him to reposition, He can't roll over independently, we offer and he refuses often." Staff C said "There is a care plan that says he refuses to turn and reposition." Review of the resident's CP with Staff C revealed the ADL CP did indicate the resident refused weights, diet and showers, but did not address repositioning.</p> <p>In an interview on 01/22/13 at 11:50 a.m., Resident #18 said he requested bed baths because he had wraps on both his feet. According to the resident he was supposed to get two baths a week. In an interview on 01/28/13 with the bath aid, Staff L, said "I do it about three times a week." On 01/28/13 at 1:31 p.m. Staff C said baths were provided at least weekly depending on preference.</p> <p>Further review of the 11/06/12 ADL Self Care Performance Deficit CP revealed the interventions listed consisted of the level of assistance the resident needed to perform ADLs, but did not indicate the type or frequency of services that should be offered or resident centered interventions to promote the listed goal. For example the Bathing Intervention stated "Resident is able to participate in washing upper body, requires extensive assist for lower body." In addition, the listed goal was to maintain current level of function and did not include resident centered goals related to ADLs including but not limited to bathing, dressing, and grooming.</p> <p>Review of POs revealed the resident had an</p>	F 279	<p>Re-educated nursing on developing comprehensive care plans related to ADL's self care performance deficit.</p> <p>Re-educated nursing on developing care plans for hypnotics and antidepressants that include appropriate diagnosis, resident centered goals, and individualized resident interventions.</p> <p>Re-educated nursing on developing care plans for hospice residents that include appropriate diagnosis and current status.</p> <p>Re-educated nursing on developing turning and repositioning care plan to reflect residents' assistance level and care needs.</p> <p>Re-educate therapy and nursing on communicating if residents wheelchairs need repair and revising the care plan if</p>	

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06/19/12 order for [redacted] everyday at bedtime for [redacted] and an additional 08/20/12 order for [redacted] at bedtime as needed for sleep. According to a 01/27/13 progress note the resident stated he was unable to sleep without the as needed dose.

The 11/06/12 [redacted] CP indicated the resident used [redacted] related to [redacted] and sleeplessness but did not include a resident centered goal for [redacted]. In addition, the CP addressed no non drug interventions to attempt to promote sleep.

Similar findings were noted for Resident #82 for whom review of the POs revealed a 12/25/12 order for [redacted] every evening for [redacted]. The 11/08/12 Antidepressant Use CP did not include the indicated diagnosis of [redacted] an identified resident goal related to sleep, nor non drug interventions to promote sleep.

RESIDENT #47 & #3
In an interview on 01/23/12 at 11:28 a.m. Resident #47 was asked about repositioning while up in her wheelchair (w/c). The resident stated she would typically reposition herself by tilting her electric w/c, but it was broken and so would not tip back.

In an interview on 01/31/13 at 9:45 a.m. staff in the rehabilitation department acknowledged they were aware the resident's w/c was broken. Records revealed a 10/10/12 conversation with the w/c vendor regarding the parts and funding approval requirements prior to repair of the tilt mechanism. In the interim, Rehab staff indicated they believed the nurses were having the resident

F 279 adjustments needed while awaiting repairs.

RCM's will monitor the need for care plan updates through daily observations of resident's change in status and 24 hour report.

Results will be reviewed in facility QA meeting for 3 months and periodically thereafter.

Date corrective action will be complete is March 27, 2013.

Director of Nursing responsible for compliance.

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F 279	Continued From page 25 lay in bed every two hours for pressure relief. The 12/12/12 Potential for alteration in skin integrity CP listed the intervention to "Cue and encourage her to tilt her w/c periodically while up in w/c"; Turn and reposition resident every 1-2 hours; green dot placed on nameplate and power chair to prompt staff to reposition resident. In an interview on 01/13/12 at 10:51 a.m. when asked if Resident #47 laid down during the day, Staff C responded, "sometimes they would offer to her and sometimes she would accept and sometimes she wouldn't." When asked about repositioning when up, Staff C said "She had a tilt function that she was able to operate on her wheelchair." When informed the tilt function on the resident's chair was broken, Staff C replied, "She never said anything." The facility failed to review and revise the resident's positioning CP to address alternative positioning methods. Similar findings were identified for Resident #3 for whom the facility's end of life CP lacked a diagnosis and which referred to the hospice provider's care plan. The certification period on the Hospice and Palliative Care IDT care plan ended on 01/22/13. The care plans were not current or complete.	F 279		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309	F 309	3-27-13 0-4

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F 309	<p>Continued From page 26</p> <p>mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to ensure timely procurement of required lab tests, notification of physician and implementation of orders for four of 27 Residents (#s 79, 57, 18 & 16); evaluate and monitor symptoms and effectiveness of edema treatment for two (#s 32 and 18) of two residents reviewed for ██████ management; and accurately perform weekly skin evaluations for three (#s 71, 54 and 51) of three residents reviewed for non-pressure skin conditions. Additionally, the facility failed to ensure administration of ██████ medication for one (#5) and maintenance of Intravenous (IV) lines for one (#54) resident. These failures placed residents at risk for unmet needs, unidentified skin issues, delay in treatment, pain and infiltrated IV lines.</p> <p>Findings include:</p> <p>DELAY IN OBTAINING LAB TESTING RESIDENTS #79 & #57 & #18 & #16 According to the 12/10/12 Minimum Data Set (MDS), Resident #79 had diagnoses which included ██████. This MDS assessed the resident sometimes demonstrated refusal of care, but exhibited no behaviors which put the resident at risk for illness or injury.</p>	F 309	<p>Resident # 79, 57, and 16 have been treated with antibiotics and currently have no signs or symptoms of urinary tract infections.</p> <p>Resident # 18 has been discharged from the facility.</p> <p>Resident #32 is currently on physical therapy for lymphedema monitoring program. A pain assessment completed and pain medications adjusted accordingly and care plan updated.</p> <p>Resident #54 intravenous therapy completed and midline removed.</p> <p>Resident with physician's orders for urinalysis will be reviewed for timely procurement of the lab test, notification of the physician, implementation of additional physician orders and care plan updated.</p>	

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Observation on 01/23/13 revealed she was self propelling in her wheelchair. The resident was unable to answer questions due to a language barrier. Record review revealed a 12/27/12 psychiatry note which indicated the resident "has been with increased agitation and confusion... the patient feels well mentally but self assesses marginally...". The physician documented, "impression... agitation and hallucinations would likely be [REDACTED] but could be due to [REDACTED] and agitation certainly from pain, suggest (blood tests), (urinalysis)...".

According to progress notes dated 12/28/12, "rec(ommendation) received from MH (mental health) for... u/a (urinalysis) with c&s (culture and sensitivity) if indicated. Order received from MD... and noted labs to be drawn on Monday and u/a to be collected asap."

In an interview on 01/25/13 at 8:18 a.m., Staff C (Resident Care Manager) confirmed staff obtained a u/a on 01/03/12, received the lab results on 01/04/13, faxed the results to the primary physician on 01/07/13, and received an order for an antibiotic on 01/09/13.

In an interview on 01/28/13, Staff C was asked why it took six days, from 12/28/12 until 01/03/13, to obtain a u/a. Staff C replied, "depending on the resident and how cooperative they are, I would hope within 24 hours... I would have to look."

Review of the Medication Administration Record (MAR) indicated the antibiotic (abo) was initiated on the evening shift on 01/09/13. When asked why there appeared to be a delay from the time the lab results were obtained and the time the

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physician was notified, Staff C replied, "It's usually done the same day, we usually fax and call." Staff C explained the facility had a practice of calling the physician daily. Staff C was unable to explain why there was a three day delay in notifying the physician of a positive urinalysis. Staff C stated, "I would expect to get results from physician in less than 24 hours, that's the standard."

In an interview on 01/25/12 at 8:33 a.m., Staff B indicated it was facility practice to call twice a day. She explained if the lab result was critical, staff would report immediately to the physician. Staff B stated she "would expect to get the antibiotic order within the next call."

Similar findings were identified for Resident #57, for whom staff received an order for a urine analysis on 01/02/13 but did not obtain it until 01/07/13.

Similar findings were identified for Resident #18 for whom staff received an order for a u/a on 01/04/13 that was not obtained until 01/09/13 in the hospital emergency room.

Similar findings were identified for Resident #16 for whom staff received an order for a u/a on 01/05/13, received the final report from the lab on 01/09/13 and received an abo order on 01/10/13. The resident did not receive the the first dose of abo until 01/11/13.

EDEMA MONITORING
The facility's Edema Monitoring Policy included directions to staff regarding residents with chronic edema. The procedure included: The Licensed Nurse will document the resident's edema status

F 309 Resident's identified with chronic edema will have the facilities edema monitoring guidelines implemented, pain assessment completed, and the plan of care reviewed and updated to reflect residents current status.

Flush orders have been implemented for residents receiving intravenous therapy.

Re-educate nurses on lab procedure to include timely follow through regarding specimen collection and notification of physician, edema monitoring, and maintenance of intravenous therapy.

Re-educate RCM's on utilizing lab audit tool and IV audit tool.

RCM to utilize the lab audit tool and IV audit tool to make sure the labs are processed in a timely manner. Review if the medical record to determine appropriate

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on a weekly basis; Objective data will include: Weekly/monthly weight according to plan of care; site of edema; pitting or non-pitting. Documentation will be done on the resident's treatment record; The RCM (Resident Care Manager) will review response to the plan of care at least quarterly and with change in edema status; Plan of care will be kept current with resident's condition.

RESIDENT #32
Observation of the resident's room during initial rounds on the morning of 01/22/13 revealed a sign posted on the wall read: "Stockings are to be handwashed and hung to dry. Do not send to laundry." On 1/25/13 at 10:45 a.m., Resident #32 expressed frustration that a CNA sent her compression stockings to the laundry two days prior and they were ruined. She stated the facility told her it would be approximately three weeks before new stockings would arrive, as they had to be special ordered.

Observation at that time revealed both of the resident's legs were [REDACTED]. Her legs were without stockings or bandages on either leg. The resident was in a wheelchair, with her legs hanging dependent.

On 01/28/13 at 2:00 p.m., the resident's legs were wrapped with bandages. Her legs remained [REDACTED]. Resident #32 stated her legs "were doing so good" before the compression stockings were ruined and that she considered this a substantial setback.

Observation on 01/29/13 at 8:40 a.m. revealed Resident #32 in bed. Her [REDACTED] leg had no stocking

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F 309	<p>Continued From page 30</p> <p>or bandage on it. Both legs appeared quite swollen. Resident #32 stated they "ached" and she was having difficulty transferring and walking with staff due to the increased weight of her [REDACTED]. "They feel so heavy."</p> <p>Review of the resident's record revealed an Impaired [REDACTED] related to CHF, [REDACTED] ([REDACTED]) and HTN care plan (CP). An intervention included "Compression stockings as ordered."</p> <p>In an interview on 01/28/13 at 8:05 a.m., Staff D, the RCM, stated the resident had physician's orders for ace wraps initiated June, 2012, but that were discontinued on 11/27/12. She stated the resident currently had no orders for compression stockings or ace wraps.</p> <p>A physician's progress note, dated 01/15/13, identified the resident with "chronic lower [REDACTED] requiring special garments for compression... Has pain associated with her [REDACTED], [REDACTED] and ([REDACTED] disease). Morbid [REDACTED] increases her discomfort... Chronic [REDACTED] changes to lower extremities. Compression garments to bilateral lower extremities." This note identified a treatment plan that included "Followed by" interdisciplinary team and occupational therapy "for [REDACTED] management, has been seen by lymphedema clinic in the past."</p> <p>In an interview on 01/28/13 at 12:20 p.m., the Occupational Therapist, Staff II, stated therapy previously wrapped the resident's legs with "lymphedema bandages" but progressed to compression stockings in September 2012. She</p>	F 309	<p>monitoring and recording of edema monitoring for residents identified.</p> <p>Results will be reviewed in facility QA meeting for 3 months and periodically thereafter.</p> <p>Date corrective action will be complete is March 27, 2013.</p> <p>Director of Nursing responsible for compliance</p>

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NAME OF PROVIDER OR SUPPLIER AVAMERE SKILLED NURSING OF TACOMA			STREET ADDRESS, CITY, STATE, ZIP CODE 3625 EAST B STREET TACOMA, WA 98404	
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F 309	<p>Continued From page 31</p> <p>stated therapy worked with the resident to be able to don and doff the stockings independently, as the resident hoped to discharge from the facility and that was one of the barriers to doing so. Staff II also stated when the resident previously wore bandages therapy measured her legs periodically in order to monitor the [REDACTED]. She stated therapy had not measured the resident's legs since she began using the compression stockings, and had not done so since the stockings became unavailable.</p> <p>On 01/30/13, Staff II provided measurements taken on 01/28/13, when compared with the last available measurements, dated 09/28/12, the resident's right lower extremity "circumferential measurements have increased since compression stockings have not been used." The circumference increased by five to 13.3 centimeters at various points of the lower extremity.</p> <p>In an interview on 01/30/13 at 3:15 p.m., Staff D was unable to locate [REDACTED] monitoring for Resident #32. She stated staff "look at her daily" but there was "not really anything documented."</p> <p>Similar findings were identified for Resident #18 whose 11/16/12 CP instructed staff to perform [REDACTED] monitoring due to [REDACTED] use, lower extremity edema, and venous insufficiency. In an interview 01/30/13 at 2:39 p.m. Staff B said there was not [REDACTED] monitoring completed for Resident #18.</p> <p>MAINTANANCE OF INTRAVENOUS LINES</p>	F 309		

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F 309	Continued From page 32 RESIDENT #54 Observation on 1/23, 24, 25, 28 & 30/13 revealed the resident had a peripherally inserted catheter in his left forearm. Record review revealed the resident recently recieved Intravenous Antibiotics (from 1/19/13 to 1/23/13); for which there was no Physicians order to flush and maintain what was identified as a midline catheter. In an interview on 01/30/13 Staff JJ confirmed the resident didn't have flush orders either with or post antibiotic. Failure to ensure orders to flush during antibiotic therapy and post therapy until the infection is determined to be resolved, place the resident at risk for an infiltrated line, rendering it useless for continued drug administration.	F 309		
F 311 SS=E	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide restorative services as recommended for three (#s 54, 47 & 79) of six residents reviewed. Failure to implement exercise programs residents were assessed to require placed them at risk for functional decline. Additionally, failure to ensure a system by which facility staff could effectively communicate with Resident #79 placed her at at risk for unmet needs, agitation, frustration and	F 311	<u>F 311</u> Physical therapy has evaluated resident #54 which determined resident had not experienced a decline. The appropriate restorative program has been initiated, and care plan updated. Interviewed resident #47 to determine any barriers regarding participating in the restorative program. Individualized restorative program initiated and care plan updated.	3-27-13 DM

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F 311	<p>Continued From page 33 increased confusion.</p> <p>Findings include:</p> <p>RESIDENT #54 Review of the 11/24/12 Minimum Data Set (MDS) revealed Resident #54 was admitted to the facility with diagnoses including [REDACTED], [REDACTED] and [REDACTED]. According to this MDS, staff assessed the resident required extensive two person assistance with transfers and toileting and one person physical assistance with personal hygiene and bed mobility.</p> <p>In an interview on 01/25/13 at 1:40 p.m., Resident #54 expressed frustration stating, "I don't understand why I am not getting therapy anymore. I can't move anywhere unless my legs get stronger and I don't see how these arm exercises are helping my legs."</p> <p>In an interview on 01/28/13 at 1:10 p.m., Staff AA (Therapy Director), stated the resident was, "no longer on therapy but is on a restorative program." According to the Therapy Restorative Aide (RA) referral form dated 12/10/12, the resident was to receive a program to "maintain functional LE (Lower Extremity) strength" which included the approach of "Supine or seated exercise with 3 lb (pound) weights and blue theraband... x 10-20 reps (repetitions) all planes." A second program had the goal of "maintain BUE (bilateral upper extremity) functional strength" using the approach of "2-4 (pound) weights all planes, blue theraband (all planes) 3x15." Each program was to take place "3-5 x per week."</p> <p>Review of the restorative program the RAs were</p>	F 311	<p>Resident #79 has been evaluated by speech language pathologist to establish effective communication plan and care plan has been updated to reflect recommendations.</p> <p>Residents with restorative programs have had been reviewed and appropriately updated in the electronic medical record.</p> <p>Evaluated residents with English as a second language to establish effective communication plan and care plan has been updated.</p> <p>Re-educate restorative nursing staff on the process for reviewing therapy recommendations, program initiation and responsibilities.</p> <p>Re-educate therapy and nursing on developing effective methods to communicate with residents with English as their second language.</p>	

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F 311	<p>Continued From page 34</p> <p>following directed them to: "have resident supine or seated. Exercises with 3 lb weights 4 reps x 2 sets 6 x weekly blue theraband (all planes) 4 reps x 2 sets 6 x weekly." In an interview on 01/28/13 at 1:17 p.m., Staff HH (Assistant Director of Nursing) was unable to explain, based on these directions, if the exercises were to be applied to the upper or lower extremities. The current RA program did not match the RA program developed by therapy. Staff O was the Restorative Nurse at the time the program was developed. Staff O, in an interview on 01/29/13, was unable to explain why the RA program did not direct staff to perform lower extremity exercises.</p> <p>In an interview on 01/29/13 at 1:45 p.m., Staff J indicated he did lower extremity exercises with the resident, stating, "I put the three pound weight on his legs and help him do 10-20 repetitions." Staff J stated he knew he was supposed to do LE exercises because he received training on these exercises from Therapy staff when the program was developed.</p> <p>In an interview on 01/30/13 at 9:07 a.m., Staff DD (Restorative Aide), indicated she worked with the resident on 01/28/13 stating, "He has an upper extremity program and he does three pound weights and the red theraband and I give him the weights... no walking or transfers, no lower extremities, all he has with us is uppers, he was complaining that the upper was doing nothing for his legs...".</p> <p>In an interview on 01/28/13 at 1:17 p.m., Staff HH indicated there should be a monthly review of</p>	F 311	<p>Observe residents through caring partner rounds for any changes in communication abilities; refer to speech language pathologist as necessary.</p> <p>Restorative nurse will review therapy recommendations, set up restorative programs and meet with restorative aides routinely to discuss residents' participation, progress and evaluate program effectiveness. Resident care plans will be updated as necessary.</p> <p>Results will be reviewed in facility QA meeting for 3 months and periodically thereafter.</p> <p>Date corrective action will be complete is March 27, 2013.</p> <p>Director of Nursing responsible for compliance.</p>		

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F 311	<p>Continued From page 35</p> <p>restorative programs in progress notes written by the Resident Care Manager (RCM). According to Staff HH, "we should address the problem to see if they are meeting their goals, see if it (RA program) needs to be adjusted in any way. Making sure your goals are realistic, if refusal find root cause and try to overcome those." Staff HH confirmed Resident #54's monthly notes did not include this information.</p> <p>In an interview on 01/28/13 at 3:40 p.m. Staff HH confirmed the RA program was unclear and should be written to reflect the program developed by Therapy. On 01/29/13 at 8:55 a.m., Staff HH said, "he is not doing the lower extremity exercises, I don't know why, there is no indication in the record why we aren't doing the lower extremities."</p> <p>RESIDENT #47 In an interview on 01/23/13 at 11:27 a.m. Resident #47 said she "very rarely" received Range of Motion (ROM) exercises.</p> <p>According to the 12/19/12 Care Plan (CP), Resident #47 received restorative passive ROM (PROM) and splinting programs to maintain functional mobility and ROM related to a potential for decline. The interventions noted the resident "Prefers that ROM program is offered between 9:00 a.m. and 12:00 p.m.. PROM of BUE (Bilateral Upper Extremities): All planes shoulders, elbow, wrist, fingers/hands before donning bilateral hand splints x 3 hours 6 x/week. Precaution: frequent refusals. Doesn't always stick to time agreed upon."</p>	F 311			

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F 311	<p>Continued From page 36</p> <p>The 12/17/12 Therapy RA Referral Form was reviewed and indicated the program was implemented to maintain BUE ROM.</p> <p>Review of the assigned tasks for the RA in the computer revealed no indication the RA program was offered or refused since implementation except for the following: A 12/26/12 CP note indicated the "Resident continues to have sporadic participation with ROM and splinting program. RA approach multiple times to provide program prior to accepting refusal. Res stated preferred time frames are 9-12 pm and are accommodated by RA without increase in participation. Tasks combined for clearer documentation. No decline in ROM noted."</p> <p>In an interview on 01/30/13 at 2:27 p.m., Staff HH looked in the computer and said it appeared the RA program was not assigned. She also said the last Restorative Nursing Note was dated 12/19/12 and read, "Resident with new RA PROM and splinting program for BUE's and bilat hands (resting hand splints). Prefers to have program done between 0900 and 12 noon. Encourage to stick to time."</p> <p>Facility staff provided paper documentation the resident was offered but refused to "Don splints up to 3 hrs at a time or 2 hrs x 2 sessions" from 12/01/12 through 12/31/12. The instructions did not include the UE PROM portion of the program. In addition, no further information was provided to indicate the resident was offered or refused the restorative program since 01/02/13.</p>	F 311		
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F 311	Continued From page 37 COMMUNICATION RESIDENT #79 According to the 12/10/12 MDS, Resident #79 was assessed to usually understand and usually be understood in conversation. According to this MDS, the resident needed or wanted an interpreter to communicate with a doctor or health care staff as her preferred language was not English. According to the Activities of Daily Living (ADL) self care performance CP, dated 12/13/12, the resident had deficits related to "primary language Spanish". Interventions included "use gestures PRN (as needed) to communicate what ADL tasks are being done." According to the mood/behavior CP, staff were to "Obtain assistance from interpreter PRN... get staff member (Spanish speaking) to calm resident down." There was no instruction to staff as to how to contact an interpreter nor was there any list of Spanish speaking staff. The Communication CP identified interventions which included, "If resident does not seem to understand, paraphrase and repeat." On 01/29/13 at 12:00 p.m. Resident #79 was observed in the dining room repeating words over and over in Spanish. Staff retrieved an interpreter from the kitchen. The resident was escorted out of the room at her request to use the restroom before lunch. After her return to the dining room, Resident #79 again spoke continuously in Spanish. Staff present attempted to communicate with her and when unable to understand what she needed retrieved a different staff interpreter from housekeeping at 12:19 p.m.	F 311			

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F 311	<p>Continued From page 38</p> <p>In an attempted interview on 01/30/13 at 2:25 p.m., the resident was asked to turn her hands. Gestures and repeated paraphrasing were ineffective. The resident smiled and started counting fingers in Spanish.</p> <p>In an interview at 2:30 p.m. on 01/30/13, Staff FF stated, "she used to have a communication board." In an interview on 01/31/13 at 11:12 a.m. Staff GG indicated the resident "Used to have a communication board when she was on the other side, but not now. Now we call (staff) in housekeeping or Staff R in kitchen...". Staff GG was unable to describe what staff were to do when neither of those two staff were working.</p> <p>In an interview on 01/31/13, Staff B stated, "she's been here for a year, and we can get her to communicate even though Spanish is her primary language" and "to go to the bathroom she can use a few words of English". Failure to ensure an effective communication plan placed the resident at risk for unmet needs and frustration.</p>	F 311		
F 312 SS=E	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 312	<p>F 312</p> <p>Nail care has been provided for resident #79.</p> <p>Nail care and oral care have been provided for resident #51. .</p> <p>Referred to dentist for extractions and denturist.</p>	<p>3-27-13 011</p>

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F 312	<p>Continued From page 39</p> <p>Based on observation, interview, and record review, the facility failed to ensure two (#s 79 and 51) of three residents reviewed for Activities of Daily Living and two supplemental (#54 and 47) residents who were dependent on staff, received oral and/or nail care and/or showers. Failure to ensure oral/nail hygiene and/or bathing services were provided placed the residents at risk for further tooth decay, pain related to gum disease, poor hygiene, and dissatisfaction with care.</p> <p>Findings include:</p> <p>RESIDENT #79 According to the 12/10/12 Minimum Data Set (MDS), Resident #79 had diagnoses which included [REDACTED] and was assessed to require extensive one person physical assistance with personal hygiene. The resident was unable to answer questions regarding personal hygiene due to a language barrier.</p> <p>Observation on 01/23/13 at 2:05 p.m. revealed the resident with fingernails which appeared dirty, long and with chipped fingernail polish. Similar observations were made on 01/28/13. On 01/30/13 at 2:50 p.m. the resident was noted with moderate brownish debris caked on the underside of the fingernails which were missing portions of the fingernail polish. Similar observations were noted on the morning of 01/31/13. On the morning of 01/31/13, these observations were shared with Staff LL, who confirmed the resident required nail care.</p> <p>RESIDENT #51 According to the 12/31/12 MDS, the resident had diagnoses including [REDACTED] and was assessed</p>	F 312	<p>Provided nail care for resident #54, and placed order on Treatment record for LN to perform routinely as resident is diabetic.</p> <p>Interviewed resident #47 in regards to shower preference and updated care plan.</p> <p>Residents have received nail care and oral care. Residents identified as needing follow up with dentist has been placed on the dentist list. Diabetic residents have orders on TAR to perform nail care routinely.</p> <p>Residents have been interviewed to identify shower and/or bath preferences and care plans updated to reflect preference. Residents will be interviewed on admit, and reviewed at quarterly care conference, for preferences.</p> <p>Re-educate nursing staff on ADL expectations to include oral care and nail care.</p>		

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F 312	<p>Continued From page 40</p> <p>to required extensive one person physical assistance with personal hygiene.</p> <p>In an interview on 01/24/13 at 9:04 a.m., the resident stated he had a broken bridge but denied chewing problems. The resident also stated he did not need staff assistance to clean his teeth.</p> <p>Observation on 01/24/13 at 8:37 a.m. revealed the resident had jagged nails on the second finger of the left hand and brown debris noted under the edges of three nails of the left hand. White debris was noted along the lower gumline of the two teeth that were visible.</p> <p>Observations on 01/28/13 prior to lunch revealed the resident had white debris along the few lower teeth observed. When asked about the use of a toothbrush, the resident indicated survey staff should look in the drawers of the bedside stand. Observation at that time revealed a broken bridge in a denture cup in the top drawer, and in the bottom drawer a bag which contained unused toothpaste and a new toothbrush still in the plastic wrapper. Similar observations were noted on 01/30/13 after breakfast and at 2:40 p.m.</p> <p>In an interview at 2:47 p.m. on 1/30/13 Staff MM (the Nursing Assistant caring for the resident) stated, "He has dentures. He doesn't like them, they are broken, he has teeth that are brushed, his toothbrush is usually in here (top drawer)." Staff MM searched the bedside stand and dresser but was unable to find oral care equipment other than the new toothbrush and toothpaste in the bottom drawer, still in the plastic bag.</p>	F 312	<p>Re-educate shower aids on updated schedule and responsibilities, to include nail care.</p> <p>Monitor nail and oral care with caring partner rounds routinely.</p> <p>Auditing process implemented to monitor completion of showers routinely.</p> <p>Results will be reviewed in facility QA meeting for 3 months and periodically thereafter.</p> <p>Date corrective action will be complete is March 27, 2013.</p> <p>Director of Nursing responsible for compliance.</p>	

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F 312	<p>Continued From page 41</p> <p>Observation on the morning of 01/31/13 revealed the resident continued to have tan and brown debris beneath his fingernails. This information was shared with Staff LL who confirmed the observation.</p> <p>RESIDENT #54 Review of the 11/24/12 MDS indicated Resident #54 was admitted to the facility with diagnoses including [REDACTED] and [REDACTED]. According to this MDS, staff assessed the resident required extensive two person assistance with transfers and one person physical assistance with personal hygiene.</p> <p>Observation on 01/23/13 at 10:01 a.m. revealed the resident had long dirty fingernails. In an interview on 01/25/13, the resident stated, "I tried to get the Aides to do it (nail care) but they said they can't because I am a diabetic." The resident stated, "the podiatrist got my feet so they're ok."</p> <p>In an interview on 01/30/13 at 10:19 a.m., Staff E indicated, "usually there's a standard for diabetics" in which Licensed Nurses (LNs) were directed to perform nail care. Staff E stated, "(Resident #54) should be receiving nail care weekly by the LNs." Staff E reviewed the Medication Administration Records, the Treatment Administration Records and physician's orders and found no direction to staff to perform nail care for Resident #54, nor any indication that it had been done.</p> <p>RESIDENT #47 According to the 09/17/12 MDS, Resident #47 was assessed to require total dependence of physical assistance with two persons for bathing.</p>	F 312	

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F 312	<p>Continued From page 42</p> <p>The 12/12/12 care plan (CP) for ADL self care performance deficit and limited mobility indicated the resident was totally dependent on staff to provide a shower and used a shower chair with two person extensive assist. The CP did not indicate with what frequency the resident would be bathed.</p> <p>In an interview on 01/28/13, Staff L said Resident #47 was scheduled for a bath twice a week on Tuesdays and Fridays. In an interview on 01/23/13 at 11:04 a.m. Resident #47 said she received a shower only once a week.</p> <p>Review of the resident record of baths given revealed Resident #47 received a bath only weekly, without documented refusals from 11/20/12-11/27/12, 12/25/12-01/04/13, 01/08/13-01/15/13 and 01/15/13-01/22/13.</p> <p>A 01/15/13 Resident Concern Report revealed Resident #47 informed facility staff "I didn't get my shower on Friday (01/11/13) and was told I would get it Saturday (01/12/13) but... I didn't get it...". The facility investigation resolution was that the resident received a shower on 01/15/13 per her "weekly schedule" and the plan was for Staff HH to "ensure showers are provided per schedule."</p> <p>In an interview on 01/30/13 at 11:44 a.m., Staff HH said the investigation verified the resident got a shower on the seventh day, not eight days as she complained. Staff HH stated the resident received the shower "weekly". When informed the resident was scheduled to be bathed twice a week, Staff HH indicated the resident should be given a shower as planned.</p>	F 312		

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F 312	Continued From page 43	F 312		
F 329	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used [REDACTED] drugs are not given these drugs unless [REDACTED] drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use [REDACTED] drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure residents received adequate monitoring of medications, medications only as ordered, as needed medications separately, non drug interventions,	F 329	<u>F 329</u> Attempted GDR for resident #57. Clarified diagnosis of psychosis with hallucinations as no hallucinations observed or reported. The resident has been reviewed and discussed by the Interdisciplinary team; the resident's behavior intervention flow sheet and care plan have been updated. Residents' psychotropic medications have been reviewed and GDR attempted for resident #26. Interviewed resident to establish root cause of refusals to get out of bed. The resident has been reviewed and discussed by the Interdisciplinary team; the resident's behavior intervention flow sheet and care plan have been updated. Comprehensive pain assessment has been completed to rule out	3-27-13 OM

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F 329	<p>Continued From page 44</p> <p>gradual dose reductions or that there were adequate indicators for the medication's use for four (#s 57, 26, 28 & 18) of ten residents reviewed for unnecessary medications. These failures placed residents at risk for adverse side effects or to receive unnecessary medications.</p> <p>Findings include:</p> <p>RESIDENT #57 According to the 10/30/12 MDS, Resident #57 had diagnoses including [REDACTED]. The 08/09/12 and 10/30/12 MDSs reflected the resident demonstrated no psychosis and no behaviors. Observations on 01/28 & 29/13 revealed the resident was able to self-propel a wheelchair in the hall, holding a baby doll in her arms. The resident was unable to participate in conversation, but was noted without agitation or anxiety.</p> <p>According to Psychiatry notes dated 11/17/11 the resident received [REDACTED] 12.5 milligrams (mgs) and 25 mgs each day and [REDACTED] 22.5 mgs each evening. The psychiatrist at that time recommended a reduction of the [REDACTED] to 15 mg. A pharmacy consult dated 01/12/12 indicated, "Psychiatry recommended reducing [REDACTED] to 15 mg hs (evening) 11/17/11. It does not appear that the primary (physician) has reviewed this consult. Please have primary review psych consult for approval of GDR."</p> <p>The PMR dated 03/06/12 reflected the resident remained on the same dose of [REDACTED] demonstrated no behaviors, had "no changes in mood/behavior... No noted psychosis or</p>	F 329	<p>pain as a contributing factor regarding the residents' verbalization of feeling down, sleep issues, and insomnia for resident #28. Evaluated residents' current medication regimen, contacted physician, and adjusted medications as ordered. Monitor residents' behaviors with the behavior intervention sheet. Updated careplan.</p> <p>Resident #18 discharged.</p> <p>Residents with no behaviors documented, but on psychotropic medications have appropriate GDR completed or physician documentation on medically contraindicated.</p> <p>Social services meet with residents who have refusals to establish root cause of refusals. Monitor those residents' behaviors with behavior intervention sheet and update their care plans.</p>	

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F 329	<p>Continued From page 45</p> <p>aggression. Continue with current plan of care at this time. Continue to monitor behaviors. No changes at this time." A PMR dated 05/15/12 revealed again, no behaviors and "no acute concerns monitor for periods of anxiety/agitation. No recent changes with medications."</p> <p>A pharmacy recommendation dated 10/10/12 included reducing [REDACTED] medications if no recent target behaviors were noted. The facility staff did not act on this recommendation.</p> <p>The PMR dated 11/01/12 indicated the resident had one episode of physically aggressive behavior for which interventions were effective. Staff documented, "Rsd has only had minimal aggressive behavior occurrences this month, interventions have proved effective. Rsd remains at baseline. Recommend no changes at his time. Follow up as needed." There was no consideration of a GDR despite a trendable lack of behaviors which warranted it's continued use at the same dose nor did staff identify at that time pharmacy made a recommendation for dose reduction which wasn't implemented.</p> <p>In an interview on 01/28/13 at 11:55 a.m., Staff I (Social Services) indicated a book was kept in the Social Services (SS) office through which they tracked quarterly [REDACTED] medication reviews. Staff I indicated at that time, "we typically follow the pharmacy recommendations" and "once the doctor says yes (to a GDR), then we do it." When asked when the review team would consider a dose reduction, Staff I stated, "it</p>	F 329	<p>Re-educated social services and nursing on GDR guidelines and tracking.</p> <p>Re-educated social services and nursing that when refusals identified staff are to meet with resident in an attempt to establish root cause of the refusal.</p> <p>Re-educated nursing that when a PRN medication is given, first the resident must be assessed to have a behavior warranting medication, a non pharm intervention attempted, and then PRN can be administered per MD order. The behavior then needs to be documented in a progress note and on the behavior log. The effectiveness also needs to be monitored. PRN pain medications should be given in combination with PRN antipsychotic medications.</p> <p>Re-educated on pharmacy recommendation policy to</p>

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F 329	<p>Continued From page 46</p> <p>depends on the resident and if they are not displaying any signs or symptoms." When asked how long the team would allow a resident to go without displaying symptoms before a GDR was considered, Staff I replied, "I don't know if we have a set time." While facility staff consistently monitored behaviors quarterly via the PMR, the review team relied solely on pharmacy and mental health evaluations to make GDR recommendations.</p> <p>According to current POs, Resident #57 received [REDACTED] for "[REDACTED] (disorder) with [REDACTED]" In an interview on 01/28/13, Staff I was unable to describe what hallucinations the resident experienced. Facility staff monitored "physical aggression" and "verbally aggressive" as the behaviors which required the use of the [REDACTED] medication.</p> <p>RESIDENT #26 According to the 11/14/12 MDS, Resident #26 had diagnoses that included [REDACTED] and [REDACTED] disorder. Review of POs revealed the resident received the [REDACTED] and [REDACTED], the mood stabilizer Depakote, the [REDACTED] and the [REDACTED]. The resident received the Depakote, [REDACTED] and [REDACTED] since at least 10/2011.</p> <p>Target behaviors for which the resident was monitored were "Refusal to get out of bed (related to) fear of hoyer (lift)", "Negative Statements" and "Refusal of care/ (treatment)" No behaviors were documented in 11/12, 12/12</p>	F 329	<p>validate GDR's are attempted when indicated.</p> <p>Re-educate staff that sleep monitoring needs to be complete before starting a medication for insomnia and if order received hours of sleep need to be monitored each shift</p> <p>Re-educate all staff on ensuring all behaviors that occurred on their shift are appropriately documented on behavior log and progress notes.</p> <p>RCM's to monitor behavior logs routinely to validate they are comprehensive and include behaviors documented on 24hour report, progress notes, and alert charting.</p> <p>Results will be reviewed in facility QA meeting for 3 months and periodically thereafter.</p>	

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F 329	<p>Continued From page 47 or 01/13:</p> <p>Review of the past three MDS assessments (dated 11/14/12, 08/23/12 and 06/07/12) revealed the resident demonstrated no behaviors, including rejection of care.</p> <p>A Psych Med Review, dated 08/30/12, identified the resident received multiple medications to treat his mood disorders. The review noted, "At this time recommend to continue with current med regimen being resident has been making improvements with socialization and participating with ADLs, once this pattern is established will reconvene next quarter for possible" reduction.</p> <p>In an interview on 01/31/13 at 9:05 a.m., Staff H, Social Services, stated the resident had a long history of not getting out of bed. When asked if the multiple medications intended to treat this history were effective, given the continued refusals she stated, "It doesn't look like it." When asked whether staff had considered the resident's concerns regarding fear and/or pain as a reason for not getting out of bed she explained the [REDACTED] was initiated in response to his reports of fear and [REDACTED]. Failure to consistently monitor behaviors and consider duplicative therapy in light of years of the target behavior with little change based on the medications placed this resident at risk for adverse and unintended side effects of multiple [REDACTED] medications.</p> <p>RESIDENT #28 According to the 11/20/12 MDS, Resident #28 was assessed as alert and oriented, with</p>	F 329	<p>Date corrective action will be complete is March 27, 2013.</p> <p>Director of Nursing responsible for compliance.</p>		

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F 329	<p>Continued From page 48</p> <p>diagnoses of [REDACTED] and [REDACTED] and exhibited no [REDACTED]. The resident indicated she felt down, had sleeping issues and experienced pain almost constantly, making it hard to sleep at night, limiting day to day activities and received routine and as needed pain medications. In addition, the resident received [REDACTED] and [REDACTED] medications.</p> <p>The 11/11/12 [REDACTED] medications CP listed the goal of "will show decreased episodes of s/s of [REDACTED] through review date." Interventions included: monitor behaviors to assist in assuring the lowest possible therapeutic dose; "monitor, record occurrence of for target behavior symptoms and document per facility protocol."</p> <p>The December 2012 Behavior/Interventions Flow sheet (BIFS) listed target behaviors of Tearful eyes, anxious statements, triggered by [REDACTED] and Isolation triggered by [REDACTED]. The BIFS was not consistently completed, missing monitoring for day shift on five days in December and eight evening shifts. In addition, staff noted the behavior of isolation occurred on day shift of 12/25, 12/26, 12/29, and 12/30 but did not indicate the number of behavior episodes as directed and failed to identify triggers or note interventions provided.</p> <p>Similar findings were noted on the November 2012 Behavior Monitoring sheet which indicated the resident exhibited behaviors of Isolation on 11/11/12, 11/17, 11/18, and 11/19. Review of the 11/20/12 Quarterly and Care Conference info under the Social Service Section indicated the resident received [REDACTED] and [REDACTED] for</p>		F 329	

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 [REDACTED] and [REDACTED]" Under the behaviors section was written, "none."
 In an interview on 01/29/13 at 9:49 a.m. Staff I said the behavior forms were reviewed in behavior meetings. Staff I said prior to administering as needed [REDACTED] the resident should "have a behavior which would warrant a prn." She explained the nurse would note the behavior exhibited "on the behavior monitor form, attempt a (non drug) intervention" and document on the back of the form or in a progress note the behavior and interventions.
 January 2013 eMar notes revealed documentation for PRN doses on 01/08 and 01/24/13 because the resident complained of increased [REDACTED]. There was no further narratives in relation to the as needed medication.
 Review of January 2013 BIMFS in conjunction with the MAR revealed the resident was administered PRN [REDACTED] on eight occasions without corresponding behaviors to indicate its use. In addition there was no documented non drug interventions attempted prior to administering the [REDACTED] medication.
 In an interview on 01/28/13 at 2:35 p.m. Staff B said the nurse was expected to "assess the resident, attempt other interventions on care plan, non pharmacological, administer medication, and document effectiveness." When asked the facility practice regarding administering as needed [REDACTED] medications simultaneously with as needed pain medications, Staff B said "They have

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to assess the resident. I know some of our residents request the medications concurrently."

Review of the December 2012 MAR revealed PRN [REDACTED] and PRN [REDACTED] were administered simultaneously to Resident #28 on 13 occasions in December, 2012. Administration of PRN pain and [REDACTED] medications together prevented the facility from assessing what was being treated and the effectiveness of each medication.

RESIDENT #18
According to the 10/23/12 Annual MDS, Resident #18 had trouble falling or staying asleep or sleeping too much, and felt tired or had little energy nearly every day.

The 11/06/12 [REDACTED] CP listed [REDACTED] use for [REDACTED] but not [REDACTED]. Interventions listed include "monitor/document/report to MD prn ongoing s/sx of [REDACTED] unaltered by [REDACTED] meds... disrupted sleep, fatigue, lethargy...".

Review of the PO revealed a 06/29/12 order for [REDACTED] at bedtime with the directions to document hours of sleep every shift for insomnia. Review of the resident's record revealed sleep monitoring was not initiated until 01/23/13.

The [REDACTED] medication review, dated 10/25/12, indicated the resident had an order for Trazodone PRN for sleep, but did not identify a target behavior of sleeplessness.

A 01/21/12 note indicted the resident was placed

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F 329	<p>Continued From page 51</p> <p>on alert for discontinuation of the PRN [REDACTED] based on a GDR request. The resident remained on scheduled [REDACTED]. "Will continue to monitor for changes in mood and sleep."</p> <p>On 01/23/13 the PRN order for [REDACTED] for [REDACTED] was reinstated and staff documented it was given on 01/23, 01/25 and 01/27/13.</p> <p>A 01/27/13 progress note revealed IDT met to discuss the recent GDR of the PRN [REDACTED]. The note indicated the Resident stated he was unable to sleep without PRN dose and after he spoke to the physician it was reinstated. The note revealed the "hours of sleep were not monitored during that time frame. Sleep monitor has been added to res chart. Will review sleep pattern and medication usage through behavior meeting in one month."</p> <p>In an interview on 01/29/13 at 11:43 a.m. Staff B said facility staff noted there was no sleep monitoring on the TAR during an audit conducted and sleep monitoring was then initiated.</p> <p>Failure to monitor hours of sleep left the facility unable to assess the effectiveness of non drug interventions and the as needed medication. In addition, the facility failed to implement a gradual dose reduction as required.</p>	F 329		
F 332 SS=E	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p>	F 332	<p>F 332</p> <p>Performed medication error report on resident #50. Changed time of iron and health shake to comply with manufactures</p>	<p>3-27-13 EM</p>

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This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5%. Five of six Licensed Nurses (Staff BB, X, CC, JJ & P) failed to follow physician's orders and/or manufacturer's recommendations for nine of 50 medications which resulted in a medication error rate of 18% with six (#s 50, 6, 5, 112, 69 & 76) of ten residents reviewed experiencing medication errors. These failures placed residents at risk to experience adverse side effects or less than the intended therapeutic effects of medications.

Findings include:

RESIDENT #50
Observation of medication pass on 01/24/13 at 8:53 a.m. revealed Staff BB prepare and administer multiple medications to Resident #50 including 81 milligrams (mg) of enteric coated [REDACTED] 325 with elemental [REDACTED] 65 mg, and one teaspoon [REDACTED] fiber laxative mixed in 1/2 a plastic cup (approximately 120 milliliters) of Health Shake. After the medications were administered, when asked if the resident had eaten breakfast, Staff BB replied, "I'm not sure." She then asked Resident #50 who said "Yes," he already ate breakfast.

Review of physician's orders (PO) revealed the aspirin ordered was not enteric coated and the ferrous sulfate was to be administered "before meals with orange juice." Both were scheduled for 9:00 a.m. The Health Shake order was for 120

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recommendation. Placed resident on alert to monitor for adverse reactions related to medication error.

Performed medication error report on resident #6. Placed resident on alert to monitor for adverse reactions related to medication error.

Performed medication error report on resident #5. Placed resident on alert to monitor for adverse reactions related to medication error.

Performed medication error report on resident #112. Placed resident on alert to monitor for adverse reactions related to medication error.

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ml. In addition, the [REDACTED] was ordered for 17 grams (Gm) mixed in eight ounces of liquid.

Review of the Nursing 2013 Drug Handbook located at the Nursing Station directed for the administration of [REDACTED], "Give tablets with juice (preferably orange juice) or water, but not with milk or antacids." Administering the medication with a dairy based liquid and not according to POs (before meals and with orange juice) constituted one medication error.

In an interview on 01/24/13 at 9:23 a.m. Staff BB said regarding the [REDACTED]: "I should have given 17 grams but instead gave five. I'm correcting the mistake, so giving 12 extra." Failure to accurately measure and administer the correct dose of [REDACTED] and with insufficient fluids constituted one medication error.

In an interview on 01/24/13 at 9:59 a.m. Staff BB reviewed the Medication Administration Record (MAR) and indicated the [REDACTED] to be given was "chewable" rather than the [REDACTED] she administered which was enteric coated. Failure to administer the correct medication constituted one medication error.

RESIDENT #6
Observation of medication pass on 01/29/13 at 10:38 a.m. revealed Staff X prepare and administer multiple medications to Resident #5 including saline nasal spray, one spray into each nare. Review of POs revealed the resident was to receive two sprays into each nare. In an interview on 01/29/13 at 11:24 a.m. Staff X said she later realized the nasal spray should have been two sprays so she went back and gave the resident

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Performed medication error report on resident #69. Placed resident on alert to monitor for adverse reactions related to medication error.

Performed medication error report on resident #76. Clarified directions on proper administration of Glipizide and updated physicians order. Placed on alert, and monitor for adverse reactions related to medication error.

Residents receiving iron and health shake have had time changed to comply with manufactures recommendation.

Residents receiving medications that need to be rotated such as nicotine patches or injectables have had administration sites rotated.

Residents receiving medications directed to be given before meals

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F 332	<p>Continued From page 54</p> <p>the additional dose. Failure to administer the correct dose during observed medication pass constituted one medication error.</p> <p>RESIDENT #5 Observation of medication pass on 01/30/13 at 8:23 a.m. revealed Staff CC prepare and administer multiple medications to Resident #5 including one whole tablet of [REDACTED] 0.1 mg. Review of POS revealed the resident was to receive half a tablet. In an interview on 01/30/13 at 10:56 a.m. Staff CC verified the MAR indicated the resident was to receive half a tablet. She stated the tablets sent from the pharmacy were whole rather than cut and she failed to cut the tablet in half as ordered. Failure to administer the dose as ordered constituted one medication error.</p> <p>RESIDENT #112 Observation of medication pass on 01/30/13 at 8:30 a.m. revealed Staff CC prepare and administer multiple medications to Resident #112, including two 7 mg [REDACTED]. Staff CC removed two patches from Resident #112's right outer upper arm, cleaned with an alcohol pad and placed the two new patches in the same spots. In an interview at 8:39 a.m. Staff CC said Resident #112 "prefers it on that side." At 10:58 a.m. Staff CC said Resident #112 "thinks if it stays in the same place it works better." According to Drugs.com, "when using this product the nicotine in your skin will still be entering your blood stream for several hours after you take off the patch", "The used patch should be removed and a new one applied to a different skin site at the same time each day." Failure to rotate sites as recommended by the manufacturer constituted</p>	F 332	<p>have been scheduled as such. Examples: glipizide, omeprazole, insulin, etc.</p> <p>Re-educate staff on medications that are to be given specific to meals times, are given accordingly.</p> <p>Re-educate staff related to following manufacturer's recommendation for medications.</p> <p>Re-educate staff on following physician's orders related to enteric coated vs. chewable.</p> <p>Re-educate staff on the five rights of medication administration and that they read the directions thoroughly.</p> <p>Re-educate staff on the importance of rotating administration sites of injectables and topical medications such as insulin or nicotine patches.</p>	

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F 332	<p>Continued From page 55 one medication error.</p> <p>RESIDENT #69 Observation of medication pass on 01/30/13 at 8:55 a.m. revealed Staff JJ prepare and administer two different insulins to Resident #69, including two units of ██████ insulin. The resident was observed to have a breakfast tray on the overbed table which was devoid of food. According to POs, staff were to do a blood glucose test with sliding scale insulin "ac" (before meals). Failure to administer insulin before meals, according to POs, had the potential to have delayed intended effects of the medication and constituted one medication error.</p> <p>RESIDENT #76 Observation of medication pass on 01/31/13 at 8:28 a.m. revealed Staff P prepare and administer multiple medications, including ██████ (a medication used to treat ██████), to Resident #76, who had just returned from breakfast. Resident #76 was observed to pour the medications into his hand and toss them into his mouth. The resident was observed to drop two of the medications on the floor. Staff P picked up one of the medications (aspirin) but did not pick up the ██████ (a medication used to treat ██████), which was an inch away from the ██████. Staff P prepared a new ██████ pill, but did not note the finasteride until the surveyor retrieved it from the ground. Failure to identify the resident did not consume an intended medication constituted one medication error.</p> <p>According to a sticker on the ██████ bingo card, staff were to administer this medication "each morning before (breakfast)". According to the</p>	F 332	<p>Monitor by observing medication passes.</p> <p>RCM's to monitor new orders received are entered into the residents' medical record correctly.</p> <p>Results will be reviewed in facility QA meeting for 3 months and periodically thereafter.</p> <p>Date corrective action will be complete is March 27, 2013.</p> <p>Director of Nursing responsible for compliance.</p>	

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F 332	Continued From page 56 Nursing Drug Handbook 2009, staff were to "give immediate-release tablet about 30 minutes before meals." In an interview on 01/31/13 Staff M confirmed staff should follow or clarify pharmacy instructions on bingo cards. Failure to administer medications prior to meals as directed constituted one medication error.	F 332		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide sufficient	F 353	<u>F 353</u> Social services interviewed residents #52, 109, 32, 47, 68, 37, 6, 71, 44, 32, 64, 116, 61, 24, 20, 5, and 59 to see if they can report a specific time or incident when they waited for call lights to identify trends. Investigations completed with specific incidents residents identified. Resident # 18 discharged. Interviewed and assessed resident #68 to identify skin impairment or psychological harm related to waiting to be laid down for one hour on 1/23/2013. Establish resident driven care plan on when wants to be laid down after dialysis.	3-27-13 OH

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staffing to meet the care needs of multiple residents including personal care and timely response to resident call lights and other requests for assistance. Eighteen (#s 52, 109, 18, 32, 47, 68, 37, 6, 71, 44, 32, 64, 116, 61, 24, 20, 5 & 59) of the 30 residents interviewed during Stage 1 felt there was insufficient staff available. In addition, review of resident council meeting minutes revealed ongoing concerns regarding call light response time. Failure to ensure sufficient staff were present to provide care and services to residents placed them at risk for unmet care needs, feelings of frustration and a diminished quality of life.

Findings include:

RESIDENT INTERVIEWS
In Stage.1, 30 residents were asked, "Do you feel there is enough staff available to make sure you get the care and assistance you need without having to wait a long time?" Nine residents responded "No" and some added the following comments:

In an interview on 01/22/13 at 10:41 a.m. Resident #52 said "Me and my room mate has had to wait for up to an hour, especially on the weekend" and "mainly on days."

In an interview on 01/22/13 at 10:51 a.m. Resident #109 said "I've waited 45 minutes for the light to be answered. They're overwhelmed." "I'll sit in the hallway and wait for an aid and sometimes I won't see anybody for 30 minutes."

In an interview on 01/22/13 at 12:05 p.m. Resident #18 said "I've waited over an hour to an

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Interviewed and assessed resident #61 to identify any adverse reactions or psychological harm related to waiting for pain medication on 1/28/2013.

Reviewed medications, completed comprehensive pain assessment and updated care plan.

Redefined staffing pattern for CNA's to ensure same number of staff present on weekends and week days. Evaluated assigned break and lunch times for staff, to provide for floor coverage while co-worker is on break.

Redefined shower schedule. If shower aide is reassigned for day shift, showers will be assigned to floor staff.

Re-educate staff to not turn off call light until resident needs are met. Training on Call Light expectations presented to each department.

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F 353	<p>Continued From page 58</p> <p>hour and a half. That's not just sometimes, that's many times."</p> <p>In an interview on 01/23/13 at 9:30 a.m. Resident #32 said "There are times the phone rings and rings, call lights are going off and there are no staff anywhere to be seen. More often on weekends and at night. Call lights go forever. I go out into the hallway after awhile to get someone to help me."</p> <p>In an interview on 01/23/13 at 11:18 a.m. Resident #47 said "There's been a few times I've had to wait over two hours." "There's been a lot of times I've had to wait over an hour." Resident #47 said the last time she had to wait she needed to be changed. "One of the times I had to wait over an hour I remember because my call light was on, the CNA came in and gave my roommate her tray and walked out without even asking me anything."</p> <p>Observation on 01/23/13 at 3:15 p.m. revealed Resident #68 wheeled onto the unit and placed in the hallway across from the nurse's station. Staff at the nurse's station were told Resident #68 was "back from [REDACTED]" Resident #68 sat in the hallway, in her wheelchair, for the next hour. She was observed to have her head bowed and eyes closed, but would periodically look around and was heard to ask several staff who walked by to put her in bed. She was placed in bed at 4:11 p.m.</p> <p>In an interview on 01/24/13 at 8:56 a.m. Resident #68 said "Yesterday after I got back from dialysis I sat in the hallway for an hour before anyone would put me to bed. They are just too busy, they</p>	F 353	<p>Re-educate nursing on techniques such as time management and work flow to help staff accomplish assignments. Assignments reviewed and adjusted based on the care needs of the residents.</p> <p>Staff re-educated on following assigned break and lunch break schedule, to provide for floor coverage during break times.</p> <p>Call light audits conducted on various shifts to validate care needs are being met.</p> <p>Audit of showers given per schedule in place to validate care needs are being met.</p> <p>Review and follow up, as needed, the minutes of the Resident Council Minutes in order to see results through the eyes of the residents.</p>	
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have too much to do."

RESIDENT COUNCIL MEETING MINUTES
Review of the Resident Council Meeting Minutes (RCMM) revealed ongoing resident concerns regarding call light response times.

The 06/04/12 RCMM identified under old business, "Call lights - Resident concerns relating to timely response to call lights have returned. Many residents state that staff enter rooms and turn off call lights without adequately addressing resident needs." Resident statements indicated the call light situation is worse on night shift and weekends. - from Residents #s 37, 6, 71, 44 and 32.

The 09/03/12 RCMM revealed "Multiple residents including, (#32, 6, 64 and 116) stated that call lights are not answered in a timely manner. Resident #116 said she has to wait for 30 minutes before somebody answers her call light. She also noted that the wait is longer during the day shift."

The 11/05/12 RCMM noted, "Another issue was the call light response time. Some residents stated that no staff could be found during NOC shift from 2 am-5 am, not on the floor or the nurses station."

The 12/03/12 RCMM indicated, "A resident stated that call lights take "forever" to get answered. A resident "ended up peeing her pants because they are taking too long. Another resident stated that CNAs are not willing to provide care for residents that are not on their run (as evidenced by) statement, "I'm not your CNA, I work at the 300 hall." The RCMM noted "Resident Council

F 353 Results will be reviewed in facility QA meeting for 3 months and periodically thereafter.

Date corrective action will be complete is March 27, 2013.

Director of Nursing responsible for compliance.

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F 353	<p>Continued From page 60 Department Response Forms were filled out and given to Nursing."</p> <p>OBSERVATIONS DURING SURVEY RESIDENT #61 Observations on 01/28/13 from the 300/400 nurse's station revealed the call light for Room 408 was on continuously from 12:42 p.m. to 12:49 p.m., from 1:05 p.m. to 1:29 p.m., and again from 1:43 p.m. to 1:52 p.m. At 1:48 p.m. an activity staff member entered the room, exited and told the nurse something. Observations at 1:49 p.m. revealed Resident #61 sitting in her room in a wheelchair. Resident #61 said "My leg hurts... no one ever pays attention to how long the lights are on." When asked what she had needed during this time period, Resident #61 replied that staff "Took me to bathroom", but "I need something because my leg really hurts - I told one guy and he went and told somebody, I need to see the nurse."</p> <p>Resident #61's roommate, Resident #24 overheard and commented "We have this problem a lot. Well (Resident #61) does, I'm fortunate I have my power chair. I just go get their ass. But (Resident #61)'s helpless, and often she ends up wetting her pants because they don't come." At 1:49 p.m. Resident #24 wheeled out to the nurse's station and asked Staff KK "whose (Resident #61's) nurse?" Staff KK told her and asked "What she need?" Resident #24 said "She needs her pain meds, she's been waiting about half an hour." Staff KK then went and told the nurse and reported to Resident #24 "she'll be there." At 1:52 p.m. the nurse took the resident pain pills and turned off the call light.</p>	F 353		
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GRIEVANCES:
According to a Resident Concern Report, on 01/15/13 Resident #47 reported "I didn't get my shower on Friday and was told I would get it Saturday but (staff member) went home early so I didn't get one today. I also need one today but the shower aid is on an escort."

Review of the shower documentation revealed the resident received a shower on 01/08/13 and 01/15/13. In an interview on 01/30/13 at 11:44 a.m. Staff HH acknowledged Resident #47 did not receive a bath for seven days. Staff HH was unable to explain why the resident did not receive a bath twice a week as care planned.

In an interview on 01/31/13 at 11:04 a.m. Staff C indicated if coverage cannot be found when an aide called in, the facility "re-tasked" a restorative aid or a shower aid to do a CNA run for the shift.

In an interview on 01/31/13 at 11:35 a.m. Staff QQ indicated the facility plan was for three shower aids on day shift. She stated there was currently one position vacant and so there were only two shower aids. She explained in the event a shower aide was "re-tasked" for a shift, the showers were not routinely assigned to the floor staff. She stated if residents "really want them then we may ask evening shift" to give them.

Review of the actual working schedule for January 2013 revealed a shower aid was pulled to the floor or one or less was scheduled on 01/02/13, 01/05/13, 01/11/13, 01/13/13, 01/23/13.

In response to a complaint filed by Resident #47 of having her "light on for over an hour" during

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F 353	<p>Continued From page 62</p> <p>breakfast, the facility conducted an audit of call light response times and provided an in-service on Call Light Responses to staff. The provided call light audit document occurred on 01/18/13 from 7:06 a.m. to 7:40 a.m. and included only two resident rooms, one of which had a 25 minute response time. Review of the Call Light Response in-service instructed "Resident call lights will be answered timely and needs met or arranged to meet needs when able."</p> <p>In an interview on 01/28/13 at 2:39 p.m. Staff B said she did not give the staff a specific time frame to respond to call lights. When asked what constituted a "timely" manner, Staff B replied, it "depends on the situation. If meal time it may be longer. If I had to put a number on it, less than 15 minutes at the max."</p> <p>Observation on 01/29/13 at 9:36 a.m. revealed a CNA, Staff RR arrive on the unit. Staff X asked her, "Where have you been?" Staff RR responded she "went outside". Staff X explained that left only one aide on the floor and "that was an issue". A transport company was noted waiting for assistance to transfer Resident #4 with a hooyer lift. Staff X stated they "had to wait due to a lack of staff available."</p> <p>In an interview on 01/28/13 at 8:30 a.m., Resident #20 stated she did not believe there were enough direct caregivers, "given the residents on this hall." She explained there were at least four residents who required a significant amount of time due to their physical and mental health needs. She stated CNAs complained they spent up to 45 minutes in each of the four resident's rooms each time they went in and that left them</p>	F 353		
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little time to provide care for the other residents. Resident #20 stated she often had to "wait up to 45 minutes on evening shift for assistance. A lot of that has to do with (Resident #5). He takes so much time staff can't get to the rest of us. Especially when there is only one person on the floor. "

RESIDENT #59
In an interview on 01/25/13 at 11:27 a.m. Resident #59 stated, "I think there's a big problem with the aids not working together, they have a lead aid, but no supervision. When I need to be turned, there is an aide who has a medical condition but she can't turn me, I have had to wait half an hour or longer to get somebody to help me."

The resident further explained, "There's another issue and that's the people who are high utilizer of resources. There are residents who keep the aide in their room for 1 1/2 hours. There are three people for whom that consistently happens. I have a Stage [REDACTED] on my coccyx/sacrum so (I can only be up for short periods of time), I say to the aide that has me I need to go to bed, then she went into (Resident # 6's) room and then she came back 45 minutes later and I am not getting back to bed on time. Today I am up, they'll get here, it takes half an hour to 40 minutes to get me up. This (staff spending up to an hour in a resident's room) happens consistently..."

In an interview on 01/31/13 at 11:35 a.m., Staff QQ explained she scheduled staffing based on

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the census. She explained the 300/400 unit had more residents so they were scheduled with more staff. She acknowledged that the 100/200 units had four residents she considered "heavy care" and she tried to split them up during the day shift a CNA would have no more than two of those residents. When asked if that worked to enable staff to provide care she replied, "We do our best."

F 353

F 363 SS=D 483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED

F 363

Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure pre-planned menus for resident meals were followed and residents were served the proper portions of certain foods. Failure to follow the menus placed all residents receiving meals prepared by the dietary department at risk for weight loss and/ or poor nutritional intake.

Findings include:

Review of menu documents for the lunch meal on 01/29/13 revealed residents were to receive parsley lemon fish fillets, parsley rice, Capri blend vegetables (which contained a mix of carrots,

F 363

Residents 113, 20, 112, 9 and 71 have been interviewed by Dietary to validate likes/dislikes.

A review of diet orders has been completed to validate the tray cards reflect the current MD diet order.

Dietary staff have been re-educated on meal preparation per menu. Residents are given the opportunity each day to complete a menu selection for the day, choosing from menu items.

Dietary staff have been re-educated in trayline procedures. To include: tray set up, reading the tray card and full diet, texture, portion sizes, (scoop sizes), temperatures documentation and timeliness of serve out.

3-27-13
DM

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F 363	<p>Continued From page 65 green beans, sliced zucchini and yellow squash) and chocolate cake.</p> <p>Observation of the preparation and service of the lunch meal on 01/29/13 revealed the following:</p> <p>In an interview at 10:30 a.m., Staff Q (cook) explained, "we temp (the food) at 11:15 a.m. and tray line starts at 11:20 a.m." In an interview at 11:17 a.m. the Registered Dietitian (RD), who was preparing the chocolate cake, stated the "CCHO" diets (controlled carbohydrates) should receive half of the regular portion of the chocolate cake.</p> <p>At 11:20 a.m. Staff Q was asked if she had prepared the pureed desserts. Staff Q indicated that still needed to be done. At 11:35 a.m., Staff Q initiated checking food temperatures. At 11:39 a.m., Staff T stated, "they're (the trays) going to be late." Tray line service was observed to start at 11:41 a.m.</p> <p>According to Staff Q, one kitchen aide prepared the trays with silverware, desserts and condiments and called out the diet type from the resident's tray cards so she could prepare the food from the steam tray. However, when the kitchen aide read the first card, he read the diet type (regular) but did not read the complete diet which included intended portion size (large), resulting in the resident being served a regular portion meal and not one and a half sized portions per the menu. The second tray was a small portion but was served regular portions rather than the half portion of fish, vegetable and rice, which was intended.</p>	F 363	<p>Tray Accuracy, menu served as written or as modified by RD, will be monitored routinely by dietary manager. RD to do random audits of tray accuracy.</p> <p>Plan of Action Date: March 27, 2013</p> <p>Dietary Manger responsible to monitor and maintain compliance.</p>	

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F 363	<p>Continued From page 66</p> <p>Additionally, staff utilized a four ounce scoop for the pureed fish, when the menu called for a three ounce serving. One tray that required large portion protein puree (four and a half ounces of puree fish) was noted to receive four ounces. When the incorrect scoop was pointed out, staff served an additional one and a half ounces. Despite tray cards which indicated residents required one and a half ounce servings, appropriate scoops were not utilized. Upon identification of this need, the RD provided the appropriate scoops. Staff were observed to provide inaccurate serving sizes of fish, rice and vegetables for both the small and large portion diets as well as diets which required, "large protein" serving sizes.</p> <p>Staff V (Kitchen Aide) identified Resident #113 disliked carrots so the Capri blend vegetables were removed from the resident's tray. There was no alternate puree vegetable prepared so the resident received only fish and rice. Resident #20 and an unidentified resident required a high protein diet but received only one serving of fish not the one and a half portion size as directed.</p> <p>Resident #112 received a regular serving of cake, not the smaller portion called for by the menu based on her diet type. Resident #s 59 and 80 also received the wrong size dessert. In addition, the last tray on the 300-400 unit cart was placed without the plate of food.</p> <p>Resident #9 received pudding rather than the pureed cake which was prepared and was on the menu. Staff were also noted to put beef gravy on the fish for all residents who required a dysphasia diet. There was no direction on the menu to put</p>	F 363		
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F 363	<p>Continued From page 67</p> <p>beef gravy on the fish.</p> <p>According to the menu, mechanical soft vegetables were to be "cut up" and dysphagia vegetables were to be "chopped". Observation revealed no vegetables prepared which were cut up or chopped. The mechanical vegetables were served without benefit of alteration and staff were observed to use the slotted spoon to attempt to cut the vegetables for the dysphagia diet as they were being scooped from the steam table.</p> <p>Resident #71, whose tray card called for a "small portion large protein" diet, received a regular serving of vegetables instead of a half serving and beef gravy on the fish.</p> <p>In an interview after the lunch meal on 01/29/13 the RD confirmed staff did not serve correct portion sizes according to the menu. When asked why the puree / slurred cake was not served to the residents, Staff T stated she removed those items because "it (the serving size) didn't look like enough." The RD and DM both indicated if the menu called for chopped or cut up vegetables, the menu should be followed.</p>	F 363		
F 364 SS=E	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 364	<p>F364</p> <p>Residents 51, 66, 71, 75, 18, 47, 83, 30, 29, 54, 52, 87, 28, 68, 27, 32, 33 & 109 have been interviewed about food preferences and choices.</p> <p>Will conduct multiple resident interviews to determine acceptance and satisfaction with meal quality, presentation, and temperature.</p>	<p>3-27-13 OM</p>

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F 364	<p>Continued From page 68</p> <p>by:</p> <p>Based on observation and interview the facility failed to ensure residents received food that was served at appropriate temperatures and consistency to maintain food quality and palatability. Eighteen (#s 51, 66, 71, 75, 18, 47, 83, 30, 29, 54, 52, 87, 28, 68, 27, 32, 33 & 109) of the 30 residents interviewed during Stage 1 voiced concerns about the temperature, taste, or look of the food served. Observations and interviews during Stage 2 revealed concerns about the taste and consistency of the food served by Resident #s 2, 22, 20, 50 & 21. Additionally, facility staff failed to ensure dairy based supplements used during medication pass were kept at the proper temperature. These failures placed all residents at risk for decreased quality of life, compromised nutritional status, and potential weight loss.</p> <p>Findings include:</p> <p>RESIDENT INTERVIEWS</p> <p>Resident #51, in an interview on 01/24/13 at 9:01 a.m., indicated food was not served at the proper temperature stating, "I had better rations during World War II, most of it was canned food, I liked it a lot better than what I get now. They grind up pork into little tiny pieces and you get maybe half a spoon of it." In an interview on 01/29/13 at 1:55 p.m., the resident stated the vegetables he got at lunch were overcooked.</p> <p>Resident #66, in an interview on 01/23/13 at 8:49 a.m. stated, "sometimes it's good, sometimes it's sh__ on a shingle, then I just get a peanut butter and jelly sandwich (PB&J). They give me fish and I hate it, I ask for PB&J and they give me</p>	F 364	<p>Dietary staff has been inserviced on the preparation, presentation, consistency, temperatures for service and taste of the food.</p> <p>Temperatures will be monitored in the kitchen before serving the plates. Test trays will be sent out each week to test at the point of service; will include all 3 meals at various times.</p> <p>Residents have been invited to participate in a Dining Committee. Residents are invited to make menu selections daily for items of their choice.</p> <p>Dietary Manager was replaced last week of January 2013. New Manager is working with staff to deliver food prepared by methods that conserve nutritive value, flavor and appearance; and food that is palatable, attractive and at proper temperature.</p> <p>Med Pass Shakes: nursing staff have been educated to keep container with ice on nursing cart for the shakes and dairy based items. Ice will be replaced prior to each shift or as needed when the ice begins to melt.</p>	

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F 364	<p>Continued From page 69</p> <p>cheese instead, PB&J is too simple for the fools."</p> <p>Resident #71, in an interview on 01/23/13 at 10:38 a.m. stated, "sometimes it's cold, breakfast especially."</p> <p>Resident #75, in an interview on 01/23/13 at 10:22 a.m. stated staff frequently put mayonnaise, which he did not like, on his food and "sometimes it's cold". The resident clarified breakfast was generally cold.</p> <p>In an interview on 01/22/13 at 12:05 p.m., Resident #18 stated, "anytime you get the food down this way you get it cold."</p> <p>Resident #47, in an interview on 01/23/13 at 11:16 a.m., indicated the food did not taste good or look appetizing stating, "No, hell no. Its overcooked or undercooked... the vegetables are always oversteamed. I won't even eat the meat."</p> <p>When asked about the temperature of food served on 01/24/13 at 8:26 a.m., Resident #83 stated, "So-so on that, sometimes, like last night's ice cream I had to drink it actually, it depends on who's in the kitchen... the weekends seem to be the worse one for cold food. The food is not quite as good as during the week, sometimes the veggies are overcooked, the meat is usually ok, usually it's the vegetables are cold or mushy."</p> <p>Resident #30, in an interview on 01/24/13 at 9:17 a.m., stated, "it's (the food) always cold, vegetables are overcooked and cold." Similar concerns were voiced by Resident #s 29, 54 and 52.</p>	F 364		

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F 364 Continued From page 70
TEST TRAY
The test tray for the lunch meal on 01/29/13 at 12:33 p.m. revealed food items at the following temperatures: milk was 49.8 degrees Fahrenheit (F), cranberry juice 53.5 F and the Capri vegetable blend 129 F. The Capri vegetables were bland and overcooked to the point the zucchini and squash were slimy and had no discernable shape. The green beans were significantly macerated and while the carrot rounds were identifiable, they were mushy. The cake was significantly dry. Staff M confirmed the vegetables were overcooked and the cake was dry at 12:38 p.m.

RESIDENT COUNSEL/GRIEVANCES
According to Resident Counsel Meeting Minutes (RCMM) dated 06/04/12, residents complained "the coffee cups are dirty", "the coffee machine in the large dining room... doesn't warm the coffee..." and "(two residents) state they have found hair in their food. No specific instances cited, no grievances filed." Residents voiced concerns regarding "Lumpy oatmeal" and the cream of wheat, "isn't being cooked right."

RCMMs dated 11/05/12 revealed residents, "stated that they are not getting their protein" because some of the meat served to them is "raw or the inside is not cooked." "Some residents reported finding hair in their food; they want the hair net policy be strictly implemented." These notes also reflected a general consensus from the residents that diet cards "are not being read and/or followed." The residents also had sentiments about the coffee not being warm enough or watered down sometimes, and "the

F 364 Nursing staff also inserviced on proper temperatures for safe storage.

Food Flavor, Appearance, and Temperature: Dietary Manager and RD to In-service on proper cooking techniques including cooking times and meal organization to ensure items are not cooked until needed. Also, education on recipes and garnish for flavor and appearance. Dietary Manager to do frequent retraining and teaching on appearance and flavor as needed.

Food Flavor, Appearance, and Temperature: Resident Food Satisfaction surveys will be completed to determine how well facility food is being received. Dietary Manager and RD to do random audits of trays in order to determine if proper flavor, appearance, and temperatures are being achieved.

Med Pass Shakes: Random audits to be completed on med pass shake temperatures to ensure adequate temperature maintenance.

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F 364	<p>Continued From page 71 creamer doesn't dissolve well. They suggested getting a better quality coffee or coffee machine."</p> <p>According to the 09/30/12 RCMMs, "food on weekend is so bad" and one resident described it as "prison food." According to the grievance log, Resident #s 25 and 29 on 11/30/12 complained that "breakfast was cold. " A 12/10/12 Resident Concern Report indicated, "(Resident complained of) alternates asked for over the weekends don't get served."</p> <p>DINING OBSERVATIONS Observation and interview of the residents in the main dining room for the lunch meal on 01/29/13 revealed the following:</p> <p>Resident #22 was observed to take a bite of the vegetable blend and and visibly grimaced. When asked how her meal was she stated, "Ok if you like the same damn thing all the time." She reported she did not like rice, which was served on her plate. She also reported the vegetables were "so soft they are hard to eat." Resident #87 stated the vegetables were "mushy", but he did not like to complain.</p> <p>Observation and interview of residents in the small dining room for the lunch meal on 01/29/13 revealed the following:</p> <p>Resident #50 stated lunch was, "not very good." Resident #21, who was not eating her lunch, had vegetables which appeared over cooked. Resident #2 was served fish despite a tray card which was clearly marked "no fish".</p>	F 364	<p>Results of the test trays, resident interviews and surveys will be reviewed for 3 months in the facility QA meeting, and periodically thereafter.</p> <p>Plan of Action Date: March 27, 2013</p> <p>The Dietary Manager is responsible to maintain compliance. Administrator has ultimate responsibility.</p>	

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F 364 Continued From page 72

F 364

In an interview on 01/31/13 at 10:58 a.m. Resident #20 stated, "The food has gotten worse in the week the new Dietary Manager has been here. She is cutting back on extras, lessening the quantity of the food. We get cream of wheat instead of oatmeal, plain yogurt instead of flavored yogurt. The quality and "doneness" of the food is even worse, if you can imagine. We didn't know that was possible, but she has managed."

MEDICATION PASS SUPPLEMENT

Observation throughout the survey revealed the strawberry nutritional supplements on the medication carts were not kept on ice or in any other way kept cool. They were noted to be on the medication cart for the entire shift from 6:00 a.m. to 2:00 p.m. According to Staff X (Licensed Nurse), in an interview on 01/29/13, the items "in the insulated box... (are) only good for eight hours". When tested on 01/29/13 at 1:45 p.m., the milk based supplement on the 100 cart was 69.5 degrees and the 200 cart was 67.1 degrees. At 1:50 p.m. on 01/29/13, the supplement on the 400 cart was 66.4 degrees and the 300 cart supplement was noted to be 72 degrees. Failure to ensure a supplement was kept at a safe and palatable temperature placed residents at risk for food borne illness and less than adequate consumption.

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

F 371

F371

3-27-13
DM

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and

No specific resident named.
Potential to impact each resident.

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F 371	<p>Continued From page 73</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to store, prepare and serve food under sanitary conditions. This failure created the potential for food contamination for all residents receiving food prepared by the dietary department.</p> <p>Findings include:</p> <p>GENERAL KITCHEN OBSERVATIONS Observation of the kitchen during the initial tour on 01/23/13 at 8:20 a.m. revealed the following: The face of the cupboards were noted to be soiled and sticky. The handles to the pull drawers to the right of the hand washing sink were soiled. The drawer to the right side of the handwashing sink was broken and did not slide. Staples and a moderate amount of debris (light brown could be degraded press board or food debris) were noted in the drawer. A red mix master appeared to be broken and was not covered (the top of the machine was partially separated from the neck/stand). The floor was noted with debris and soiled proximal to the coving. There were three partial bags of gravy mix which were opened and not dated and a partial bag of dehydrated mashed potatoes which was open and not dated. A box of cream of rice cereal was noted to be open and not sealed. The tray on which sat</p>	F 371	<p><i>Food Storage:</i> Dietary staff re-educated on proper storage of food items. To include date item was opened, cover label and date in refrigerator, sealed and covered in dry storage. No items to be stored on the floor.</p> <p><i>Cleaning/Sanitation:</i> Staff to maintain proper cleaning and sanitation techniques in order to preserve resident safety. Deep clean to be completed and cleaning schedule created and implemented for maintaining the sanitation in the kitchen. Dietary staff re-educated on proper cleaning techniques and utilization of the cleaning schedules.</p> <p><i>Use of the 3 Compartment Sink:</i> New sanitizer dispensers were installed during the survey. Staff educated on the use of 3 compartment sink to properly to disinfect/ sanitize equipment.</p>	
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F 371	<p>Continued From page 74</p> <p>multiple large bottles of soy sauce and vinegar was soiled with dried sticky splatter and food debris. A bottle of Worcestershire sauce, dated 11/01/10, was open and the lid was loose on top but not secured.</p> <p>Near the second sink (near exit door and supply cupboard), the doors and door handle were noted to be soiled with sticky residue. The floor by the back door was soiled and the molding around the supply door was missing. A space of approximately two square feet in the supply closet was missing linoleum. The vent in the supply closet was coated with a moderate amount of dust.</p> <p>The ceiling was noted with areas of peeling tape and what appeared to be bubbled surface.</p> <p>DRY STORAGE The dry storage room contained a bag of rice, located inside a plastic bin, which was open and not dated. Two bins of pasta and one plastic bin of Cheerios were open and not dated. Scattered debris was noted on the floor. Multiple boxes, including corn flakes, cake mix, juices, fruit salad and chips were noted stored on the floor. In an interview at 8:40 a.m., Staff S stated they received their food shipment the previous day.</p> <p>REFRIGERATOR The wall in the walk in fridge was significantly moist with condensation. A bag of grated cheese was open and not dated. A container was labeled "boiled eggs" but the aluminum foil was punctured exposing the contents of the bin to air. A tan colored mixture in small molds was labeled "chicken" and dated 10-09-12. The plastic wrap</p>	F 371	<p><i>Hand-washing:</i> staff will be re-educated on proper hand washing procedures. Including when serving in the dining rooms, to wear gloves when directly touching a food item.</p> <p><i>Food Storage:</i> Dietary Manger to complete routine audits of all storage areas to ensure appropriate food storage.</p> <p><i>Cleaning/Sanitation:</i> Dietary Manager to complete routine cleaning schedule audits and checks. RD to complete random audits of kitchen sanitation.</p> <p><i>Use of the 3 Compartment Sink:</i> RD to complete random audits of 3 compartment sink techniques and utilization.</p> <p><i>Hand-washing:</i> Random audits completed throughout the facility to ensure proper hand-washing/ glove use.</p> <p>Plan of Action Date: March 27, 2013</p> <p>Dietary Manger responsible to oversee compliance. Administrator to monitor compliance.</p>	
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NAME OF PROVIDER OR SUPPLIER AVAMERE SKILLED NURSING OF TACOMA	STREET ADDRESS, CITY, STATE, ZIP CODE 3625 EAST B STREET TACOMA, WA 98404
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F 371	<p>Continued From page 75</p> <p>was removed from the molds thus the food was not covered.</p> <p>Multiple containers of high protein drinks were on a tray which was noted with a pool of clear liquid. A tray of white Styrofoam bowls was unlabeled and undated. Multiple boxes, labeled "casa Solana enchilada," and "frozen crinkle cut fries" and "Turkey breast" were noted on the floor. Staff S in an interview at that time indicated, "they shouldn't be on the floor" and they had "probably been there since yesterday's delivery."</p> <p>A tray of salad dressing in small bowls was uncovered and unlabeled. Two large bags of mixed cabbage greens were noted to be wilted with a moderate amount of liquid. According to staff, the bags had been there, "for a couple of days". In an interview on 01/23/13 at 9:10 a.m., Staff U stated staff did not intend to use this cabbage mix and that it had been delivered in that condition. She was unable to explain why the degraded cabbage mix was not removed from food storage. Staff U additionally indicated the box located on the floor of the walk in refrigerator labeled, "frozen crinkle cut fries" actually contained onions and other vegetables. One large container of yogurt was noted open and undated.</p> <p>The walk in freezer was noted to have multiple boxes stored on the floor including: strawberries and hamburger buns. Wrappers and pieces of tape were noted on the floor. A full tray of small bowls filled with ice cream was uncovered and undated.</p> <p>A large vent in the ceiling was missing it's cover,</p>	F 371		
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F 371 Continued From page 76
thus there was a large uncovered hole in the ceiling. Similar observations were made on 01/25/13, 01/28/13 and 01/29/12. A soiled metal vent cover was noted on the floor next to the freezer. A large meat slicer was uncovered beneath the uncovered vent. A large standing mixing bowl was also noted without a cover.

In an interview on 01/23/13 at 9:10 a.m., Staff U (Dietary Manager (DM)) stated, "we do keep them (meat slicer, standing mixer, etc) covered." She was unable to explain why they were not covered when observed. She further stated food items in the fridge, "should be covered and labeled."

Multiple containers of spices (pumpkin pie spice, ground rosemary and cayenne pepper) were noted not dated and with no bar code, which might indicate their age. A staff member, during kitchen observation, was noted to use his foot to close the refrigerator door, proximal to the handle where one would close the door.

Broken or missing handles were noted on cupboards labeled "salad plate" and "glassware". The drawers at the end of the island containing the steam table were without handles and were broken. Two of two cupboards did not close effectively.

OBSERVATIONS ON 01/29/13
Observation of the kitchen at 9:48 a.m. on 01/29/13 revealed Staff R cleaning dishes at the three compartment sink. According to Staff R, the dishwasher was broken, thus they were doing dishes by hand. Staff T (DM) confirmed the rinse cycle of the dishwasher was not stopping and they were waiting for repairs to be made. In an

F 371

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F 371 Continued From page 77
interview at 9:54 a.m., Staff V (Dietary Aide), indicated the machine usually worked, and only had issues " like, every four months."

A sign above the three compartment sink indicated dishes in the first compartment should be cleaned with detergent in water that was "120-130 degrees", however it was temped at 101.2 degrees. Staff confirmed the temperature was 101 degrees.

According to Staff Q (Cook), she had put "two capfuls" of detergent into the first compartment. According to directions on the detergent bottle (Gone) there should be "one ounce per 6 gallons of water". The cap of the detergent bottle had no demarcation to determine volume. According to Staff T, the sink contained 15 gallons of water.

In an interview with the RD, she stated if the sign above the sink instructed staff to have a water temperature of 120 to 130 degrees, "that's what we should be doing." Failure to ensure adequate detergent and proper temperature detracted from staff's ability to ensure dishes were sanitized.

Additional observation during the lunch meal on 01/29/13 revealed Resident #32 reported she had a 1/2 inch black hair in her salad. This was confirmed by Staff GG.

Dining observations on 01/22/13 at 12:41 p.m. revealed a resident returned a finished lunch tray to the main dining room. Staff NN retrieved the soiled tray, put it into the tray cart and returned to feeding another resident without washing her hands.

F 371

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F 371 Continued From page 78
Observation on 01/24/13 at 8:40 a.m., revealed Staff VV in the assisted dining room washed her hands for only 10 seconds.

Dining observations on 01/29/13 at 12:52 p.m. revealed Staff OO remove a peanut butter and jelly sandwich from a bag on Resident #25's tray, cut the sandwich in half and hand the sandwich to Resident #25. Bare hand contact with ready to eat foods placed the resident at risk of food borne illness.

F 371

F 425 SS=D 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

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

F 425

F 425

Resident #60 has completed prescribed eye drops. No adverse effects observed from missing doses of eye drops.

Clarified resident #76 medication, glipizide, to be administered per pharmacy/manufacturers recommendation (i.e. before breakfast); medication label and physician orders match.

Reviewed resident #110 chart to identify any adverse reactions related to accuracy of blood sugar checks and insulin administration.

*3-27-13
DIA*

This LEVEL B is not met as evidenced by:

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F 425	<p>Continued From page 79</p> <p>Based on interview and record review it was determined the facility failed to: clarify and or follow Physician Orders/Manufacturer recommendations, ensure routine medications were available and/or administered as ordered for three (#s 60, 110 & 28) of ten residents reviewed for unnecessary medications. These failures placed residents at risk for uncontrolled blood sugars, pain, delayed treatment and medication errors.</p> <p>Findings include:</p> <p>RESIDENT #60 Review of Physician Orders (PO) revealed Resident #60 underwent eye surgery on 01/03/13. He returned from the surgery with orders for three separate eye drops.</p> <p>Review of the MAR and progress notes revealed both the [REDACTED] and [REDACTED] were not administered for four scheduled doses on 01/03/13 and 01/04/13 due to they "had not arrived from the pharmacy". In addition, six doses of the [REDACTED] were not administered on 01/03, 01/04 and 01/05/13 due to they were "not delivered from pharmacy".</p> <p>In an interview on 01/31/13 at 10:36 a.m., Staff D (Resident Care Manager) stated the pharmacy typically delivered medications each night shift. In addition, if a medication was urgent, they would deliver throughout the day. She stated she did not expect the pharmacy to take more than 24 hours to deliver eye drops, especially as the resident was post-surgery. She then called the pharmacy</p>	F 425	<p>Clarified orders for resident #28's pain medications.</p> <p>Residents with medications that should be given before breakfast have been scheduled with times before breakfast.</p> <p>Physician orders verified with directions on medication labels to validate they match.</p> <p>Reviewed physicians orders to identify any orders written that would place them at risk for medication errors. Clarify any orders identified.</p> <p>Re-educate nursing that if medication not available to call pharmacy to identify when medication will be available, notify physician of missed dose, and place a progress note in chart.</p> <p>Re-educate nursing on reading directions of medications thoroughly and administering them as written.</p>	
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F 425	<p>Continued From page 80</p> <p>and discovered the eye drops were delivered on 01/04/13 however she was unsure of what time they arrived. Staff D was unable to explain how Resident #60 missed a dose of the [REDACTED] on 01/05/13, nor could she explain why the drops were not ordered in a more emergent manner to prevent the resident from missing multiple doses.</p> <p>RESIDENT #76 Observation of medication pass on 01/31/13 at 8:28 a.m. revealed Staff P prepare and administer multiple medications, including [REDACTED] (a medication used to treat [REDACTED]), to Resident #76, who had just returned from breakfast. According to a sticker on the [REDACTED] bingo card, staff were to administer this medication "each morning before (breakfast)", however, there was no instruction in the PO to do so. According to the Nursing Drug Handbook 2009, staff were to "give immediate-release tablet about 30 minutes before meals." In an interview on 01/31/13 Staff M confirmed staff should follow or clarify pharmacy instructions on bingo cards.</p> <p>RESIDENT #110 Review of the [REDACTED] Administration Record revealed staff failed to consistently administer the accurate amount of insulin, failed to document the resident's blood sugar (BS), and failed to consistently rotate injection sites. Instances of these failures include: On 01/11/13 at 2000 staff documented the administration of four units of insulin but did not document the BS; on 01/12/13 at 0700 zero units of insulin were documented with no BS. At 1600 on 01/21/13, the BS was noted as "0" and ten units of insulin were given.</p> <p>At 1100 on 01/20/13 staff noted a BS of 341 and</p>	F 425	<p>Re-educate nursing on the importance of rotating sites of insulin administration and documenting the location and units given.</p> <p>Re-educate nursing that medications should be given as ordered. If physician order and bingo card directions do not match, clarify with physician, and correct any discrepancies before giving medication.</p> <p>RCM to check 24hour report routinely to identify any medications not available, call pharmacy to ensure timely delivery and validate charge nurse took appropriate steps as outlined above.</p> <p>RCM to validate physicians orders are entered correctly and per manufacturer's recommendation, routinely with 24 hour report.</p>	

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F 425	<p>Continued From page 81</p> <p>ten units of insulin administered. The PO revealed eight units should have been given. On 01/22/13 at 0700, staff recorded a BS of 345 and that ten units of insulin were given. The PO revealed eight units should have been administered. At 2000 on 01/27/13, the BS was 188 and staff noted two units of insulin were given instead of the three directed by POs.</p> <p>At 2000 on 01/23/13, the BS was noted as 157, however there was a blank where units of insulin given should be noted. At 1600 on 01/26/13, the BS was noted as 583. Instead of the units of insulin given, staff recorded a check mark.</p> <p>In an interview on 01/31/12 at 11:22 a.m., Staff C stated it appeared the wrong dose was given on the above mentioned times. She also acknowledged staff failed to consistently document either the blood sugar or the amount of insulin given.</p> <p>In addition, staff frequently noted the administration of insulin in the same site up to five times in a row. Staff C explained staff should rotate insulin injection sites "to prevent skin impairment and tenderness." She stated, "you are introducing a medication so you want to rotate." She stated it appeared staff were not rotating injection sites as expected.</p> <p>RESIDENT #28 Review of Resident #28's POs revealed a 09/06/12 routine order for [REDACTED] to be given at bedtime, scheduled for 8:00 p.m. every evening and an 09/16/12 as needed order (PRN) for [REDACTED] with instructions "do not administer within 4 hours of (night) dose."</p>	F 425	<p>Monitor by observing medication passes.</p> <p>Results will be reviewed in facility QA meeting for 3 months and periodically thereafter.</p> <p>Date corrective action will be complete is March 27, 2013.</p> <p>Director of Nursing responsible for compliance.</p>	

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F 425 Continued From page 82

Review of the January MAR revealed documentation of the PRN dose having been given within four hours of the routine dose on 01/01/13 at 11:08 p.m., 01/02/13 at 10:19 p.m., 01/03/13 at 7:47 p.m., 01/13/13 at 4:58 p.m., 01/17/13 at 9:00 p.m., and 01/18/13 at 10:38 p.m.

Review of page 62 and 64 of the Narcotic Disposition Record verified a nurse administered the Oxycodone doses within four hours of each other on 01/13/13 at 5:00 p.m. and 8:00 p.m., on 01/14/13 at 8:00 p.m. and 11:00 p.m., on 01/18/13 at 8:00 p.m. and 10:38 p.m., and on 01/26/13 at 8:00 p.m. and 11:45 p.m. Failure to give medications as ordered placed the resident at risk of sedation and other adverse side effects.

F 425

F 428 SS=D 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON

The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility

F 428

F 428

Resident #57 medications and behaviors reviewed to see if appropriate for GDR per previous pharmacy recommendation. Order received to attempt GDR. Monitor residents' behaviors with the behavior intervention sheet. Updated careplan.

Lab results drawn on 1/11/13 are now included in resident #75's chart.

3-57-13
01

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F 428	<p>Continued From page 83</p> <p>failed to ensure an effective drug regimen review or pharmacist recommendations in a timely manner for two (#s 57 & 75) of ten residents reviewed for unnecessary medications. This failure placed residents at risk for adverse side effects from unnecessary medications.</p> <p>Findings include:</p> <p>RESIDENT #57 Record review revealed a pharmacy recommendation form dated 10/10/12 which indicated, "FDA Boxed warning statement in the antipsychotic's product information identifies a potential increased risk of mortality in elderly individuals taking [REDACTED] medications for [REDACTED] related behavioral disorders. The 2012 American Geriatrics Society Beers Criteria also recommends avoiding [REDACTED] medications used for behavior problems in [REDACTED] due to an increased risk for stroke and mortality. The quality of evidence is reported as high and the strength of their recommendation is strong."</p> <p>This pharmacist recommended: "If no recent target behaviors or, in the absence of compelling reason not to, please consider reducing the dose to 12.5 (milligrams twice a day)."</p> <p>According to facility documents, the physician agreed to the dose reduction on 11/10/12 but staff failed to transcribe the order, thus the medication was never reduced. Failure to act on pharmacy recommendations/ physician orders (PO) resulted in this resident receiving an unnecessary drug and the potential to experience unwanted side effects.</p>	F 428	<p>Reviewed pharmacy recommendation process to validate follow up occurs timely.</p> <p>Initiated lab audit form to be reviewed routinely.</p> <p>Re-educate staff on pharmacy recommendation procedure and expectations.</p> <p>Re-educate staff on lab procedure so that orders for lab work is carried out timely, including MD notification of the results. A validation system has been established related to pharmacy recommendations.</p> <p>RCM's to monitor labs with lab audit tool routinely.</p> <p>Results will be reviewed in facility QA meeting for 3 months and periodically thereafter.</p> <p>Date corrective action will be complete is March 27, 2013.</p> <p>Director of Nursing responsible for compliance.</p>	
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F 428	<p>Continued From page 84</p> <p>RESIDENT #75</p> <p>A pharmacy Consultation Report, dated 10/10/12, recommended the resident receive a basic metabolic panel (lab test) on the "next convenient lab day and 6 months thereafter due to takes a diuretic and has not had an electrolyte panel in the previous 6 months." The physician did not sign the consultation as reviewed until one month later, on 11/10/12, when he agreed to the recommendation.</p> <p>A PO, dated 11/19/12, was written for a comprehensive metabolic panel. There was no indication the lab was completed.</p> <p>In an interview on 01/30/13 at 12:15 p.m., Staff C explained pharmacy consultations should be reviewed by the physician within three days. She stated it should not have taken a month for the physician to review the consultation for Resident #75.</p> <p>Staff C was unable to locate the lab ordered on 11/19/12. After contacting the laboratory she stated the lab was not drawn until 01/11/13. At that time, the resident was noted to have a critical low value of potassium which required treatment. In addition, the lab noted levels that were out of normal range for three other values (██████████ A/G Ratio and SGOT-AST).</p>	F 428		
F 441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT. SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and</p>	F 441	<p><u>F 441</u></p> <p>Residents #79 and 54 do not have a current infection, no precautions needed currently.</p>	<p>3-27-13 DM</p>

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F 441	<p>Continued From page 85 to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure consistent</p>	F 441	<p>Reviewed resident #6 chart to ensure no adverse reactions related to LN putting nasal spray in her pocket for transport. Replaced resident's nasal spray.</p> <p>Residents with current infections have correct precautions in place.</p> <p>Re-educate nursing on responsibilities of implementing infection control procedures when receiving new orders to include placing precautions on the care plan, kardex, sign on door, and appropriate personal protective equipment in room.</p> <p>Re-educate nursing on infection control related to placing items in their pockets.</p>	

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F 441	<p>Continued From page 86</p> <p>implementation of an effective infection control to ensure staff implemented and followed isolation precautions and used appropriate handling of medication containers placed all residents at risk for the spread of infection.</p> <p>Findings include:</p> <p>In an interview on 01/25/13, Staff O (Staff Development/Infection Control Nurse) discussed the facility practice for residents who are ESBL (a multi-drug resistant enzyme produced by some bacteria) positive. "We do put them on isolation. If they are symptomatic we put them on contact precautions, if they are colonized and they are asymptomatic, we don't have to put them on isolation." Staff O explained that for residents on contact precautions, staff should wear gloves when entering the room and wear a gown if they came in contact with the resident.</p> <p>In an interview on the afternoon of 01/28/13 Staff O indicated that Resident #79 was being treated for ESBL and was on contact precautions. She explained, "When they go into her room they should wear gloves, if they are taking care of her... if they are doing peri-care they would wear a gown and gloves."</p> <p>When asked about Resident #54, who was identified with and being treated for ESBL, Staff O stated, "he is also colonized ESBL, it's been quite a while ago; he's colonized; if he was being treated then they should glove gown, they should be gowning and gloving when giving a bath." Staff O was unaware the resident was being treated for a symptomatic UTI (Urinary Tract Infection).</p>	F 441	<p>RCM's to verify correct precautions implemented and care plans in place via 24hour report tool. Monitor medication pass to validate appropriate infection control procedures being followed.</p> <p>Results will be reviewed in facility QA meeting for 3 months and periodically thereafter.</p> <p>Date corrective action will be complete is March 27, 2013.</p> <p>Director of Nursing responsible for compliance.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441

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Multiple observations throughout the survey revealed staff enter Resident #54's room without gloves and provide personal care without benefit of a gown. Observation with Staff O on 01/28/13 at approximately 2:30 p.m. confirmed multiple staff enter the room without benefit of gloves and a CNA who was providing incontinent care without benefit of a gown.

In an interview at that time, Staff O indicated "the nurse on the floor who takes the order (for the antibiotic) should be responsible for implementing the contact isolation and the temporary Care Plan (CP) and for implementing the CP. The RCM doing the follow up will verify the contact isolation is implemented and CP updated... to have the staff actually do it (precautions) is nursing supervisory, following through to make sure it's taking place and holding (staff) accountable."

In an interview with Staff C on 01/30/13, "the nurse on the floor who takes the order should be responsible for implementing the contact isolation and the temporary CP once you enter the CP, you would link it to the Kardex so the floor staff would know about the precautions. The RCM doing the follow-up will verify the contact isolation is implement and CP updated."

In an interview on 01/28/13 at approximately 2:20 p.m., Staff L (shower aide) indicated if a resident was on contact precautions there would be an alert in the computerized Kardex system notifying the Nursing Assistants (NAs). Staff L stated there was no indication on the Kardex that either Resident #79 or 54 had an alert regarding isolation.

F 441

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F 441	Continued From page 88 In an interview on the morning of 01/30/13, Staff L indicated she provided bed baths for Resident #54. Staff L stated she wore a gown when she bathed the resident "because otherwise I would get all wet." Staff L then clarified she used a resident sleeping gown, not Personal Protective Equipment supplied by the facility which would provide protection against bodily fluids. Additionally, observations throughout the survey revealed staff entered Resident #79's room without gloves. Staff were observed on multiple occasions (including on 01/28/13 at 2:30 p.m. and 01/29/13 at 8:45 a.m.) holding the resident's hand and touching the resident and her clothing without use of gloves. MEDICATION PASS Observation during medication pass on 01/29/13 at 10:40 a.m. revealed Staff X (Licensed Nurse) put nasal spray, and a box of artificial tears, intended for Resident #6, in her right pocket. Staff X administered the nasal spray, a Spiriva inhaler and placed the Spiriva, eye drops and nasal spray back in her pocket.	F 441			
F 466 SS=D	483.70(h)(1) PROCEDURES TO ENSURE WATER AVAILABILITY The facility must establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply.	F 466	F 466 No specific resident named. Potential to impact each resident.	3-27-13 007	

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F 466

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This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review, the facility failed to establish clear procedures to ensure that water would be available in an emergency. In addition, bottled water designated for emergencies was found to be past its "Best if Used by Date." Contradictory written policies and no clear method for estimating the volume of water required placed residents at risk for dehydration during the loss of normal water supply.

Findings include:

In an interview on 01/30/13 at 9:15 a.m., Staff G, Maintenance Director provided the Emergency Procedure manual, which he indicated was located at the main receptionist's desk and would be used by staff in the event of an emergency. Review of the binder revealed three different policies that addressed emergency water loss procedures.

Staff G then explained he was newly employed by the facility and had not yet reviewed the emergency water policy. He was unable to determine which policy was current, as only one was dated. He stated the facility had more than enough water in the event of an emergency stored in the hot water heater and bottled water, however he was unable to explain how the amount of water required was determined.

Staff G indicated approximately 50 gallon jugs of bottled water were stored in the pantry.

F 466

The emergency water procedure has been revised to establish a clear process of water being available should there be an emergency and loss of city supplied water.

The procedure outlines the location of the water, the amount of the water, how to access the water and that there is 1 gallon per resident and staff member for minimum of 3 days. Total of 743 gallons of water.

Outdated water has been removed.

Staff has been educated on the revised policy and the location and access of the emergency water supply.

Will be monitored by the Maintenance Director for on going compliance.

Date: 3/27/2013.

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F 466	Continued From page 90 Observation of the water revealed several had a "Best if Used by" date of 11/01/12. Staff G stated although it could be used if necessary, he believed the facility policy would be for the water to be discarded. He stated there should be a procedure to periodically rotate the water supply. Upon further review, Staff G located an additional Water Outage policy, dated 12/21/06, which was not in the Emergency Procedure manual. This policy identified the facility should have a "minimum of 2 1/2 gallons of drinking water for each resident plus the number of routinely staffed employees on day shift (2 1/2 gallons = 1/2 gallon per day for five days.)" The Emergency Water Loss Procedures had space for the facility to note how much water would be on hand per patient day, but it was blank. Staff G acknowledged it was unclear how the facility estimated the amount of water needed. He also stated there was no clear procedure for how to distribute the water, based on the contradictory policies kept in the manual.	F 466		
F 514 SS=E	483.75(1)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and	F 514	F 514 Resident # 28's restorative program has been entered into electronic medical record. Lab results scanned into resident #79 and 57's chart.	3-27-13 DM

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F 514	<p>Continued From page 91</p> <p>services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to maintain complete and accurate medical records for eight (#s 3, 18, 28, 54, 57, 60, 71 & 79) of 27 sample records reviewed. Failure to ensure documents including care plans, inventory records, Restorative Records, Behavior Monitoring records, Care Records and lab results were complete, accurate and readily accessible placed residents at risk for unmet needs.</p> <p>Findings included:</p> <p>RESIDENT #28 According to the 11/20/12 MDS, Resident #28 received therapy services during the MDS assessment period. Review of the resident's record revealed a therapy referral to restorative on 12/13/12. A 12/16/12 progress note indicated the RA program was in place to maintain functional mobility through ambulation/PROM as tolerated.</p> <p>In an interview on 01/25/13 at 10:22 a.m., Resident #28 said "I was walking down the hall and my legs gave out". Resident #28 said she had a restorative program which was previously offered five days a week, but had been decreased to three days a week. She did not participate with ambulation with the restorative aid as "my MS () is flared up so I</p>	F 514	<p>Resident #54 chart reviewed for correct documentation of ADL's in chart.</p> <p>Resident #18 discharged.</p> <p>Clarified resident #71 has appropriate skin check orders in her chart.</p> <p>Resident #60 has appropriate behavior log in 24hour binder with documented month and year on record.</p> <p>Removed resident #9 care conference forms from resident #3 chart.</p> <p>Residents with restorative programs have been entered into residents electronic medical record. Residents charts reviewed for correct documentation of ADL's in chart.</p> <p>Showers are being documented when performed and validation method established to monitor.</p>		

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F 514	<p>Continued From page 92 can't."</p> <p>Review of RA Program documentation in the computer for December 2012 indicated the resident had only one occasion, 12/26/12, was it noted the resident was offered restorative services and refused. Review of the January 2013 reports provided no indication the resident was offered or refused ambulation.</p> <p>In an interview on 01/30/13 at 2:12 p.m., Staff HH said the RA was to provide AAROM to bilateral lower extremities, resting hand splints, Passive and Active ROM to upper extremities for 10 repetitions or as patient tolerated or ambulate. Staff HH reviewed the instructions in the computer and was unable to determine services the Restorative aid provided or if the resident had ambulated. Staff HH stated, "I'm going to have to ask someone."</p> <p>In an interview on 01/30/13 at 2:18 p.m. Staff J said he offered Resident #28 services six days a week for UE ROM, elbow splints, hand splints, then ROM on LEs or walking instead. When asked when the last time Resident #28 ambulated, Staff J replied, "It's been a minute because her legs have been acting up."</p> <p>When asked where he documented the ambulation, Staff J said "on the computer." The instructions entered into the computer did not instruct staff to document how far the resident walked and instructed staff to document only if the program was accepted or refused. On occasions where the resident was noted to have refused services it could not be determined what service was refused. Staff J stated, "It could have been either (the ROM or the ambulation) because</p>	F 514	<p>Residents have skin checks documented in their charts.</p> <p>Behavior management sheets and pain logs have appropriate month and year on them.</p> <p>Scanned in paper documents that are to be included in the medical records.</p> <p>Re-educate nursing to document in electronic medical record, not on a separate form that is not part of the resident chart.</p> <p>Re-educate nursing on the importance of correctly documenting in residents charts.</p> <p>Re-educate nursing on completely filling out behavior management sheets and pain logs.</p> <p>Re-educate nursing to follow weekly skin check orders and document in resident chart with each skin check.</p>	

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F 514	<p>Continued From page 93 its together (in the computer)."</p> <p>On 01/30/13 at 3:12 p.m. Staff HH provided handwritten documentation of the January 2013 Restorative Program which she said was in the Restorative Binder. The form instructed staff to provide PROM to bilateral lower extremities x 10 reps all planes. Staff documented providing PROM for 80 repetitions over 15 minutes on 01/02, 01/03, 01/04 and 01/21/13. In contrast, the RA Program documentation in the computer indicated the resident received AAROM to BLE x 10 reps to all planes on 01/02, 01/03, 01/08, 01/09, 01/10, 01/12, 01/13, 01/14, 01/15, 01/18, 01/19, 01/21, 01/23 and 01/24 for 15 minutes each time.</p> <p>Review of the handwritten sheet indicated the resident ambulated on nine days in January 2013. The resident had not been offered or refused any aspect of the restorative program since 01/23/13, seven days prior.</p> <p>Documentation in the record was inconsistent with entries logged into the computerized record for the resident.</p> <p>LAB RESULTS Record review revealed labs were drawn for Resident #79 on 12/31/12. While a progress note dated 12/31/12 indicated the results were received, there were no results available in the record. Staff C acknowledged on 01/28/13 that the results were not present.</p> <p>Similar findings were identified for Resident #57 who had a [REDACTED] and sensitivity done on</p>	F 514	<p>A validation system has been established with initiating new restorative programs and programs will be reviewed monthly to determine ongoing effectiveness.</p> <p>RCM's to monitor labs entered into residents chart with 24 hour follow through tool routinely.</p> <p>RCM to monitor behavior and pain logs routinely to verify are filled out accurately and comprehensively.</p>	

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F 514	<p>Continued From page 94</p> <p>01/08/13. The results were not in the resident's record because, according to Staff E the facility was "in between medical records staff".</p> <p>CARE RECORDS RESIDENT #54 According to Nursing Aide documentation, Resident #54 was transferred on ten occasions during the month of January with only weight bearing support and on multiple other occasions with total dependence on staff. Both if these were contrary to staff reports the resident was bedbound. In an interview on 01/30/13 Staff C (Resident Care Manager-RCM) indicated this documentation appeared unlikely as she had not heard the resident had been out of bed. In an interview on 01/30/13 at 3:15 p.m., Staff B confirmed the aid documentation regarding care provided to Resident #54 was inaccurate as the resident was not transferred.</p> <p>RESIDENT #18 In an interview on 01/22/13 Resident #18 said he was supposed to get two baths a week, but most weeks he received only one. Review of the computerized bath aid documentation for December 2012 revealed the resident usually received a bath twice a week with the exception when he was not offered or refused a bath from 12/14/12 until 12/21/12. On 01/31/13 the facility provided a Shower and Weight Chart of all resident baths offered on 12/18/12 in which it was documented the resident refused a shower but had been given a bed-bath. The care provided was not documented in the resident record.</p>	F 514	<p>RCM's to monitor the 24 hour report form to spot check documentation is complete in resident's charts timely.</p> <p>Developed auditing process to monitor completion of showers routinely.</p> <p>Monitor accuracy of ADL documentation with quarterly MDS.</p> <p>Results will be reviewed in facility QA meeting for 3 months and periodically thereafter.</p> <p>Date corrective action will be complete is March 27, 2013.</p> <p>Director of Nursing responsible for compliance.</p>	

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F 514	<p>Continued From page 95</p> <p>RESIDENT #71 Observation of Resident #71 on 01/23/13 at 10:50 a.m. revealed a small abrasion on her medial right calf. In an interview on 01/26/13 at 10:04 a.m., the resident stated she did not know how it happened and denied pain.</p> <p>Review of nursing's weekly skin audits revealed staff noted they performed checks each week in January, including on 01/17/13 and 01/24/13. The Treatment Record (TAR) included directions to staff to "state (N) no skin issues, (Y) new skin issues. Document in (computerized system)." Staff recorded a check mark, but neither an "N" or a "Y" in the system on either 01/17 or 01/24/13.</p> <p>BEHAVIOR MONITORING FLOW SHEETS On 01/28/13 at 12:45 p.m., Staff X was asked to located the current Behavior / Intervention Monthly Flow Records for Resident #60. She provided a binder labeled "100 Hall Behavior and Pain". None of the individual flow sheets in the binder contained a month or year. In addition, the forms were completed through the 31st day. Upon further questioning, Staff X stated the binder did not contain the current month of monitoring forms and she provided another binder with January 2013 forms. At that time, Staff X and Staff CC were unable to determine what month the undated forms were for.</p> <p>WRONG CHART In Resident #3's electronic record, a Care Conference Invitation notification for Resident #9 was located.</p>	F 514		
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F 514	Continued From page 96	F 514		
F 518 SS=E	<p>483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS</p> <p>The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review the facility failed to ensure that three (X, Y & W) of four staff interviewed had working knowledge of facility emergency procedures including how to respond to earthquakes and armed intruders. This placed residents at risk for unsafe or inadequate care in the event of an emergency.</p> <p>Findings include:</p> <p>Review of facility emergency procedures revealed the following:</p> <p>During an Earthquake: A. Take care of yourself first. B. Stay calm. C. Get into one of the safe areas as soon as possible. D. Place your hands over your head for protection. E. Kneel down in a hunched position next to inside wall.</p> <p>Armed Person / Intruder: In the event you are confronted by an armed person(s), i is</p>	F 518	<p>F 518</p> <p>No specific resident was named. Each resident has the potential to be affected.</p> <p>Re-educate staff on emergency procedures to include earthquake and armed intruder.</p> <p>Random interviews with staff will be completed to validate knowledge of emergency procedures and/or know where to locate procedures.</p> <p>Emergency procedures will be reviewed in detail during orientation with new employees.</p> <p>Results will be reviewed in facility QA meeting for 3 months and periodically thereafter.</p>	3-27-13 om

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NAME OF PROVIDER OR SUPPLIER AVAMERE SKILLED NURSING OF TACOMA			STREET ADDRESS, CITY, STATE, ZIP CODE 3625 EAST B STREET TACOMA, WA 98404		
(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 518	Continued From page 97 recommended that you: 1). Comply with their demands whenever possible. 2). Slow things down. 3). Communicate. 4). Stay calm. In an interview on 01/29/13 at 2:15 p.m., Staff X did not recall receiving training regarding how to respond to an armed intruder. She stated she thought she should give the intruder what he asked for, but stated she was not sure that was the facility's policy. When asked what she would do in an earthquake, Staff X stated she would move residents away from windows. When asked if that would be her immediate response during the earthquake she stated, "I have residents, there is no time to save myself." In an interview on 01/30/13 at 9:00 a.m., Staff Y stated in the event of an earthquake she stated if residents were nearby she would "help them get into a good area." If no residents were close she would cover herself. In an interview on 01/30/13 at 2:40 p.m., Staff W identified herself as having worked at the facility for approximately five months. She stated she did not remember being trained on how to respond to an armed intruder. She stated, "I guess just give them what they want, but I honestly don't think we talked about it (in orientation)." She stated in the event of an earthquake she would "tend to the residents." She was "not sure" whether to close doors or not in the event of an earthquake.	F 518	Date corrective action will be complete is March 27, 2013. Administrator responsible to oversee compliance.		