

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

IDR AMENDED

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PRINTED: 03/13
FORM APPRC
OMB NO. 0938-C

1407

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505004	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/09/2013
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NAME OF PROVIDER OR SUPPLIER ISSAQUAH NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 805 FRONT STREET ISSAQUAH, WA 98027
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INITIAL COMMENTS

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This report is the result of an unannounced Standard Quality Indicator Survey conducted at Issaquah Nursing and Rehabilitation Center on 01/03/13, 01/04/13, 01/07/13, 01/08/13 and 01/09/13. A sample of 28 residents was selected from a census of 117. The sample included 26 current residents, the record of one former and/or discharged residents, and one supplemental resident.

The survey was conducted by:

- ██████████, RN, MN
- ██████████, MSW
- ██████████, MSW
- ██████████, RN, MN
- ██████████, RN, MSN

The survey team is from:

Department of Social & Health Services
Aging & Disability Services Administration
Residential Care Services, Region 2, Unit E
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Linda Ranco 3-13-13 for IDR Program Manager
Residential Care Services Date

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Melissa (Lisa) B. Shobenrauck RN BSN ADMINISTRATOR 3/19/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF 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: Based on observation and interview, the facility failed to ensure a dignified dining experience in two of five dining areas. These failures placed residents at risk to not feel valued and respected and contributed to decreased quality of life.</p> <p>Findings include:</p> <p>Observation of the noon meal on 01/03/13 in the Coho Dining Room revealed the following: At 12:28 p.m., four residents were seated and waited for their meals. The trays arrived at 12:41 p.m. and staff immediately served Resident #211, who began to eat independently. Resident #86 sat at the table with Resident #211 and watched him eat. At 12:44 p.m., staff served a male resident at a different table. Staff placed a clothing protector around his neck without speaking to him. At 12:46 p.m. Staff R said, "Ready for lunch (Resident #3)?" and put a clothing protector around her neck without asking or telling her what he was doing. Two more residents were then served their trays at different tables. At 12:48 p.m., Resident #86, who sat next to Resident #211 and watched him eat, was served his tray. Staff R stated, "Ok (Resident #86), ready for lunch?" He placed a clothing protector around Resident #86's neck without</p>	F 241	<p>F241 Dignity and Respect of Individuality</p> <p>Residents in the Coho and Fireside Dining Rooms are receiving care in a manner and environment that promotes their dignity and respect. Each resident has been assessed by social services and found to have no negative outcomes from the alleged failed practice.</p> <p>Interviewable residents have been interviewed by social services staff to identify any concerns related to their dining experience. Any identified concerns have been documented on the facility grievance form and resolved through the facility's grievance process.</p> <p>Facility staff, including staff members identified in the citation, have received additional in-service training regarding the importance of providing care in a manner that will enhance dignity and respect for all residents. This training included information on providing a dignified dining experience.</p> <p>The facility grievance process was reviewed with residents during the recent resident council meeting.</p> <p>The Administrator will track, trend, and summarize the results of the grievance reports and results will be reported to the Quality Assurance Performance</p>	2/25/13
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F 241	<p>Continued From page 2 asking or telling him what he was doing.</p> <p>At 12:49 p.m., Staff S brought Resident #222 into the dining room and stated aloud, "I'm going to work with her today." Staff began to feed residents at 12:51 p.m. At 12:54 p.m., Staff J (Speech Therapist) entered the dining room and sat next to Resident #222, on the opposite side from Staff S. At 1:02 p.m., Staff J asked Staff S, "Is she not feeding herself at all? I think staff ordered different medication last night. I noticed she has had a change and isn't feeding herself." This conversation was made in front of Resident #222 as well as five other residents and a visitor of Resident #211's. Staff J then said to Resident #222, "How are you doing today? You look like you're sleepy. Can you open your eyes?" all in rapid succession.</p> <p>At 1:05 p.m., Staff J continued to speak aloud to Staff S. She said, "The thing I was initially concerned with was her respiratory status but now I'm worried about her [REDACTED]. Last night she stopped in the middle of chewing. She just stopped and the food was still there." At 1:16 p.m., Staff J called to Staff T, who sat at another table feeding a resident, "What was the medication that changed?" He replied, "I'm not really sure." Staff J continued, "So that's what I'm thinking is even if you hear a swallow it's not a full swallow... it's a delayed cough... she's not swallowing...".</p> <p>RESIDENT #224: On 01/08/13 between 1:05 and 1:12 p.m. in the Coho dining room, Staff J was seated by Resident #224 as he ate his lunch. Staff J was heard to cue and discuss in a loud voice how the</p>	F 241	<p>Improvement Committee (QAPI) to validate ongoing compliance.</p> <p>Compliance Date: 2/25/2013</p>		

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F 241	<p>Continued From page 3</p> <p>resident should use his tongue to sweep his mouth and clear food he still needed to swallow. As Resident #224 was seated at the table, Staff J asked him to open his mouth so she could check to see if he still had food in his mouth, and commented, "Oh, that looks really good". Two other residents were seated at the same table. One unidentified female resident was with a visitor and was trying to carry on a social conversation. Other residents and staff in the room could hear the therapist's comments to Resident #224 as she provided therapy during the meal.</p> <p>Staff J stated, "You may not feel how much is on your left side, but there are two big pieces of chicken, use your tongue to the left... can you feel the food to the left... use your tongue...". Staff J also was heard to make comments about the resident's profession and asked about his prior treatment at a hospital. Her interactions with this resident did not reflect an awareness the resident might want his treatment to be conducted in a less public setting, and did not promote a dignified dining experience for Resident #224 or the six other residents in this dining room. As observed until 1:12 pm, Staff J continued to cue the resident to use his tongue to sweep the left side of his mouth as he ate his lunch.</p> <p>In an interview on 01/09/13, Staff V, Resident Care Manager, stated therapists usually conducted speech therapy in the resident's room. She asked if there were other residents in the dining room at the time these observations were made and when informed there were stated, "Oh no, they shouldn't do treatment. Maybe if they sit and watch, but that would be it."</p>	F 241		

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F 241 Continued From page 4 .

Similar observations were made on 01/03/13 when one rehab staff member said to another, "I'm afraid he might start eating too fast, his appetite has come back." This statement was made in front of the resident she was speaking about, instead of speaking to the resident or outside of his hearing range.

Observation of the lunch meal in the Fireside dining room on 01/03/13 revealed staff served residents who sat at different tables. This created a situation where residents watched their tablemates eat while they waited for their meal for up to 15 minutes.

In addition, a visitor was observed to put clothing protectors on all of the residents in the Fireside dining room without first asking if they preferred one.

F 241

F 272 483.20(b)(1) COMPREHENSIVE
SS=D ASSESSMENTS

The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:
Identification and demographic information;
Customary routine;
Cognitive patterns;
Communication;

F 272

F272
Comprehensive Assessments

The MDS assessments for residents #62, 7, 206 and 212 have been corrected to accurately reflect each resident's status.

MDS assessments for all other residents will be reviewed for inaccuracies and corrected as necessary during their next scheduled review.

2/5/13

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Vision;
Mood and behavior patterns;
Psychosocial well-being;
Physical functioning and structural problems;
Contenance;
Disease diagnosis and health conditions;
Dental and nutritional status;
Skin conditions;
Activity pursuit;
Medications;
Special treatments and procedures;
Discharge potential;
Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and
Documentation of participation in assessment.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to accurately assess four (#s 62, 7, 206 & 212) of 18 residents reviewed. Failure to accurately assess skin conditions, activity of daily living function, range of motion and weight loss placed these residents at risk for unidentified and/or unmet needs.

Findings include:

RESIDENT #62
According to the 12/03/12 Minimum Data Set

F 272

Staff responsible for the completion of MDS assessments have received additional training on accurate coding including coding of skin conditions, activity of daily living function, range of motion and calculating significant weight changes.

The Corporate Patient Services consultant is auditing a random sample of MDS assessments monthly for accuracy. Any inaccuracies identified will be immediately corrected.

Audits are being tracked, trended and summarized by the Patient Services Consultant and forwarded to the QAPI committee for review.

The Director of Nursing Services will validate ongoing compliance.

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F 272	<p>Continued From page 6</p> <p>(MDS), the resident was admitted to the facility in [REDACTED], had a stage one or greater wound and was at risk for developing a [REDACTED] but did not have a current unhealed [REDACTED]. The 12/05/12 Care Area Assessment (CAA) indicated the resident had, "only one [REDACTED] on his right (ankle area)". According to the resident's current care plan, the resident had a [REDACTED]"</p> <p>According to wound clinic notes dated 12/06/12, "Wound and surrounding skin remain improved but continued pressure on malleolus by wheelchair strut impairing progress." This document also reflected, "(patient's) lateral right leg sitting against hard wheelchair strut."</p> <p>According to wound clinic notes dated 12/12/12, "the wound and surrounding skin remain improved but continued pressure on (ankle area) by wheelchair strut impairing progress."</p> <p>Observation on 01/07/13 at 10:07 a.m. revealed the resident in a wheelchair at his bedside. The resident was noted to wear bilateral boots and the right foot was in direct contact with the right wheelchair strut, which was padded with foam</p> <p>In an interview on 01/03/13 at 11:25 a.m. Staff E, the Resident Care Manager, stated the resident had a [REDACTED]" wound to the right ankle. According to telephone orders dated 12/20/12, staff were to treat the "right lateral malleolus [REDACTED]..."</p> <p>In an interview on 01/09/13 at 10:44 a.m., Staff H, Corporate Nursing Staff, stated this wound was a PU and indicated the MDS was incorrectly coded.</p>	F 272			

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RESIDENT #7

According to the 10/15/12 MDS, the resident had diagnoses of [REDACTED] and [REDACTED]. This assessment indicated the resident required the supervision of one person for bed mobility and one person physical assistance with supervision for toileting. Staff assessed the resident had no functional limitation in range of motion.

According to the 01/01/13 MDS, the resident required more assistance with Activities of Daily Living (ADLs). Staff determined the resident now required extensive two person assistance with bed mobility and extensive one person assistance with toileting along with newly developed functional impairment on one side of the upper extremity

Observations on 01/03/13, 01/07/13 and 01/08/13 revealed the resident got up from bed, ambulated to the bathroom, toileted himself and returned to bed independently without staff assistance or supervision.

When asked, in an interview on 01/09/13 at 8:25 a.m., why the 01/01/13 MDS reflected a decline in bed mobility, toileting and ambulating in the corridor, Staff D confirmed the MDS reflected the resident had a change. She stated, "maybe he had a bad day in the look-back period." Staff D clarified the CAA should have reflected why the resident required more assistance in ADLs but it did not.

Upon review of the compressed ADL report (a report generated which reflects the residents

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F 272	<p>Continued From page 8</p> <p>actual level of assistance required during the assessment period), Staff D indicated the resident consistently needed a higher level of support at night. Staff D stated, "he should have been coded as a three on the previous MDS (10/15/12 MDS); so should have the toileting; both should have been a 3,2 (extensive one person assistance)." Staff D elaborated the 10/15/12 MDS was inaccurate relating to the resident's ADLs. In addition, she stated the 01/01/13 MDS inaccurately reflected the resident had one sided functional impairment of the upper extremities.</p> <p>RESIDENT #206 Review of physician's orders revealed Resident #206 received [REDACTED] for [REDACTED] and [REDACTED] for "[REDACTED]." He also received a high calorie supplement three times a day. The 11/16/12 Nutrition care plan revealed the resident had "poor intake."</p> <p>According to the 11/26/12 MDS, the resident experienced a weight loss of 5% or more in the past month, however this MDS assessed the weight loss was physician prescribed.</p> <p>In an interview on 01/09/13 at 10:18 a.m., Staff D, the MDS coordinator, stated the weight loss should not have been coded as physician prescribed, as the resident was not on a [REDACTED] and his medications and care plans indicated the weight loss was not desired.</p> <p>RESIDENT #212 Review of the weight records for Resident #212 revealed she experienced weight loss related to [REDACTED] and [REDACTED]. Her weight was 205.6</p>	F 272		

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F 272	Continued From page 9 pounds on 11/17/12, 194.6 pounds on 12/13/12 and 188.9 pounds on 12/25/12. The 12/27/12 MDS did not assess the resident as having experienced weight loss. In an interview on 01/09/13 at 10:30 a.m., Staff D reviewed the resident's weights. She stated the resident lost 7.3%, which should have been reflected on the MDS as a physician prescribed weight loss.	F 272		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one (#62) of three dependent residents reviewed for Activities of Daily Living received oral care. Failure to ensure oral hygiene services were provided placed the resident at risk for further [REDACTED] pain related to [REDACTED] and dissatisfaction with care. Findings include: RESIDENT #62 Resident #62, according to the 12/03/12 Minimum Data Set (MDS), was assessed to understand and be understood in conversation, had no	F 312	F312 ADL Care Provided for Dependent Residents Resident #62 is receiving care and accurate documentation of oral hygiene. All dependant residents have been reviewed to assure oral hygiene is being provided and accurately documented. Resident Care Managers are making daily rounds to validate ADL care is being provided according to each resident's plan of care. Results of care rounds are being forwarded to the Director of Nursing through the QAPI Committee for tracking, trending, and analysis. The Director of Nursing Services is validating ongoing compliance. Compliance Date: 2/25/2012	2/25/13

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F 312	<p>Continued From page 10</p> <p>cognitive impairment and required extensive one person physical assistance for [REDACTED]. This MDS also indicated the resident had no behaviors which interfered with care and did not refuse care.</p> <p>According to the 09/14/12 Oral/Dental Health care plan (CP), staff were to "assist res(ident) to brush teeth use Listerine along gum line, setup and allow resident to do as much as able" and that brushing aid was to occur with a "soft toothbrush 2 times/day." The CP was specific that, "on days wake late set up for [REDACTED] res(ident) to call if needs assist."</p> <p>In an interview on 01/04/13 at 10:21 a.m., the resident stated staff did not help as necessary to clean his teeth, stating, "They haven't done anything since my teeth have been pulled." The resident further clarified there was no use of small soft sponges used to provide oral care (toothettes) and no attempted use of mouthwash. When asked if he had brushed his teeth the resident stated, "I haven't even touched 'em, the gums have been sore and are just now getting better."</p> <p>Record review revealed the resident had [REDACTED] on 11/13/12 which required the [REDACTED] of [REDACTED]. Progress notes dated 11/15/12 indicated the resident "denies pain or discomfort at this time." Similar entries were made on 11/05/12, 11/16/12, 11/17/12, 11/21/12, 11/24/12, 11/25/12, 11/27/12, 11/29/12, 12/01/12 and 12/02/12. Progress notes dated 12/04/12 indicated the resident "is alert and oriented x 3 and able to make his needs known" and "has recently been refusing his downgraded diet, but</p>	F 312		

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F 312	Continued From page 11 this is due to recent [REDACTED] and not a non compliancy issue at this time. (Resident) reports that everyday he's getting a little better after his surgery, but says it still hurts at times." Observation on 01/07/13 at 10:40 a.m. revealed the resident's oral care supplies were in a drawer. The toothbrush was under a Ziploc bag, some papers and other miscellaneous items. The toothbrush was noted to be dry and was observed unmoved from that position on 01/08/13 at 1:15 p.m. and 01/09/13 at 11:35 a.m. In an interview on 01/09/13 at 11:40 a.m., the resident reiterated he had not had his teeth brushed nor had oral care (including the use of Listerine or soft oral sponges) of any kind since his oral surgery (on 11/13/12) because his [REDACTED]. Observation of the Care Tracker guide on 01/09/13 directed staff to brush teeth and gum lines "with Listerine am/pm." In an interview on 01/09/13 at 11:35 a.m. Staff E, the Resident Care Manager, stated the resident was a reliable reporter. At 11:46 a.m., Staff E indicated she was unaware the resident had not received oral care since his surgery stating, "no, he should be getting oral care there's no reason his teeth can't be brushed." Staff H, Corporate Nursing Staff, in an interview on 01/09/13, indicated the CP should have been updated to reflect options for alternative oral care should have been attempted.	F 312			
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a	F 318			

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F 318 Continued From page 12
resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to ensure one (#7) of three sample residents reviewed for Range of Motion received adequate assessment, appropriate care planning, and preventative care to improve and/or maintain functional range of motion. Failure to provide services this resident was assessed to require placed him at risk for decline in range of motion and function.

Findings include:

Refer to CFR 483.20(b)(viii), F-272, Comprehensive Assessment

RESIDENT #7
Resident #7 was admitted to the facility in [REDACTED] with diagnoses including [REDACTED] and [REDACTED]. According to the 01/01/13 Minimum Data Set (MDS), Resident #7 was determined to have severe cognitive impairment, was usually able to understand and be understood in conversation and rejected care on one to three of the last seven days. The 01/01/13 Care Area Assessment (CAA) indicated the resident, "is resistant to cares being provided for him at times and staff are aware of discontinuing and attempting cares at a later time. This is usually

F 318

F318
Increase/Prevent Decrease in Range of Motion 2/25/13

Resident # 7's range of motion has been re-evaluated by Occupational Therapy. The plan of care has been updated to reflect therapy recommendations and additional interventions to maintain the resident's range of motion.

Residents who have been identified on their comprehensive assessment with a limited range of motion have been screened by rehabilitation care services. Each resident's plan of care was reviewed and revised as necessary to assure appropriate treatment and services were in place to increase range of motion or prevent further decreases in range of motion.

Nursing management will assess residents for any functional changes in range of motion in coordination with the MDS assessment. Any identified declines in functional range of motion will result in referral to rehabilitation care services for additional evaluation. The resident's care plan will be updated as necessary to assure interventions to increase range of motion or prevent further decreases in range of motion are in place.

Residents with identified functional declines in range of motion on the MDS assessment will be audited monthly by the medical records auditor to assure

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F 318	<p>Continued From page 13</p> <p>effective. He is independent with walking about the facility using a cane." Staff further documented, "(Resident) continues to demonstrate intermittent behaviors such as resistance to care and agitation. He is generally able to be redirected."</p> <p>According to hospital records dated 06/07/09, the resident had a motor exam which revealed a score of 1-2/5 (a test which measures motor ability on a scale of 0-5) "for the left third, fourth, and fifth finger extensors" and the resident was determined to have [REDACTED] in the [REDACTED]"</p> <p>According to facility Occupational Therapy (OT) notes dated 6/30/09, the resident had "strength of the Left (L) upper extremity (UE)" which was "2/5 resulting in difficulty pushing from sit to stand and completing functional transfers safely... (Left) UE impaired with flexor tone and change for contracture due to refusal to wear splint." Therapy Staff documented, "L UE impaired due to residual effects of stroke however pt (patient) does have slight active range UE."</p> <p>There was no further evidence staff addressed the resident's [REDACTED] again until a progress note dated 12/07/11 indicated, "When attempting to do nail care on res(ident) noted 2 fingers on the right hand with contractures pressing into palm, unable to cut nails as pt would not let LN (Licensed Nurse) attempt to straighten a little. ARNP notified, new orders for OT eval(uation), OT notified..."</p> <p>While the resident's record contained no evidence of a 12/2011 OT evaluation, facility staff</p>	F 318		
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F 318	<p>Continued From page 14</p> <p>were able to request and obtain 12/08/11 OT evaluation documents which assessed the resident with "Pain under (Left) 4th/5th digits is red and with odor, at high risk for skin breakdown" and "Pain level determined based upon behaviors exhibited by patient... Pt. states that his hand "hurts a little" at rest. Pt says "ouch" and removes hand quickly from therapists during Passive Range of Motion (PROM)." OT staff at that time indicated the resident's pain limited the patient's functional activities and "PROM difficult and minimal in [REDACTED] 4th/5th digits due to flexor tone and spasticity and development contractures." Additionally, OT staff at that time determined the resident was at risk for "decreased skin integrity, increased tone, limiting functional movement, increased pain and contracture(s)."</p> <p>According to the 12/11 OT evaluation, staff assessed the resident, "...requires skilled OT services to decrease painful condition of UE in order to enhance patient's quality of life by improving patients skin integrity and ability to be able to return to prior level of living." In addition, "Splint/Orthotic Recommendations: it is recommended the patient be further assessed for order/fabricate on [REDACTED] for 8 hours/day to at all times as appropriate in order to improve PROM (Passive Range of Motion) for adequate hygiene, reduce pain caused by muscle tightening and develop/establish wearing schedule". The OT evaluation indicated the resident would benefit from treatment, "five times a week" for "4 weeks."</p> <p>OT staff identified long term goals for this treatment plan which included: "Pt will</p>	F 318		

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F 318 Continued From page 15
demonstrate good tolerance of [REDACTED] including increase PROM for proper hygiene and decreased pain and good carryover by caregivers 100% of the time for return of Previous Level of Function" and "Pt will be assessed for 4th/5th digit of L hand extension splint to maintain position for [REDACTED] and decrease pain...".

F 318

According to billing documents, the resident received OT for 45 minutes on 12/20/11 and was not seen again. There was no documentation indicating what treatment was provided nor why the treatment plan was not followed as outlined in the 12/08/11 evaluation. Facility staff was asked to provide any rationale or documentation to support why this was the case. No information was provided. In an interview on 01/09/13 at 11:35 a.m., Staff H, Corporate Nursing Staff, was unable to explain why the OT treatment plans of 12/11 were not implemented.

According to Care Plan (CP) documents dated 12/07/11, the resident was identified at risk for skin breakdown related to "[REDACTED]". Another CP indicated the resident was at risk for alteration in comfort related to: episodes of pain secondary to... [REDACTED]. The goal listed was the resident would experience no pain, however, there were no interventions which addressed pain related to the hand contracture.

Record review revealed no assessment, intervention or monitoring of the resident's left hand contracture since the initial OT contact in 12/11, a period of over a year.

There were no goals regarding prevention of

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F 318 Continued From page 16
reduction in Range of Motion (ROM), but interventions included, "check right hand daily for skin breakdown, keep nails short and clean as able". A 12/07/11 CP amendment indicated, "right hand finger contractures, refused hand "carrot" refuses assist with cane." A 12/07/11 intervention listed "OT (occupational Therapy) eval and treat for contractures."

In an interview on 01/03/13 at 11:22 a.m., Staff E indicated the resident had a hand [REDACTED] and did not receive restorative, stating, "We tried a carrot and he absolutely refused." There was no other documentation in the record, outside the CP entry, that a carrot was ever attempted or refused nor of any reattempts of treatment to prevent worsening of the existing contractures.

Observation on 01/04/13 at 08:37 a.m. revealed the resident's [REDACTED] appeared to be missing the distal portion of the second finger and the third, fourth and fifth fingers appeared contracted, curled up into the palm of the resident's hand. Upon request, the resident was able to partially, but not fully, extend these fingers.

Upon request, on 01/08/13 at 10:42 a.m., Staff E, the Resident Care Manager (RCM) did ROM with the resident's [REDACTED]. The fourth and fifth fingers were noted to be curled down toward the palm and the resident was unable to extend them upon request.

According to Staff E, the resident had "contractures to the fourth and fifth fingers of the [REDACTED], he does have very little range, barely enough to put one finger between his finger and palm, the other three fingers have some limited

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range but he is able to extend them somewhat."

In an interview on the morning of 01/09/13, Staff D, MDS staff, indicated contractures were typically tracked by Restorative staff. Staff D explained that when a resident was identified with a contracture or altered ROM, they were referred to therapy, therapy would develop a treatment plan and then the resident would usually be referred to Restorative, where staff would assess, monitor and treat the presenting problem. Staff D confirmed Resident #7 was not in a Restorative program and thus there was no means to determine if the resident had a contracture or if it worsened.

F 318

F 323 SS=D 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to provide adequate supervision to prevent Resident #95, one of one supplemental residents reviewed for accidents, from accessing an outdoor area, which was to be secured by an alarm to alert staff when residents exited the building. Failure to ensure this resident was provided with supervision when exiting the

F 323

F323
Free of Accident Hazards/Supervision/Devices

Resident #95 is receiving adequate supervision and assistance devices to prevent accidents.

All other residents residing on the secure unit have been reviewed and care plans have been updated to accurately reflect the level of supervision and assistance devices required to prevent accidents.

The facility has implemented and staff have received in-service training on monitoring door alarms on the secure unit each shift to assure alarms are turned on and functioning.

Additionally, the interdisciplinary team is reviewing the 24 hour report to identify any

8/5/13

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building during cold weather created the potential for harm for this resident, as well as other residents of this unit with known histories of wandering without regard for their safety.

Findings include:

Resident #95 was admitted [REDACTED] with care needs related to [REDACTED] with [REDACTED] and [REDACTED]. According to his Minimum Data Set (MDS) assessment dated 11/28/12, Resident #95 required limited assistance from staff when walking on the unit. His care plan, dated 10/20/12, also identified this resident was to be assisted by staff with ambulation "as needed".

While the MDS of 11/28/12 did not identify a problem with wandering for this resident, his care plan identified he was at risk for "wandering and/or potential elopement". Interventions identified to promote this resident's safety included "Staff to help assist res (resident) if wants to amb (ambulate) outside (as) needed to help decrease anxiety" and "SCU (Special Care Unit) doors alarmed per protocol". The care plan also directed staff to "cue Res to use FWW" (front wheeled walker). A fall risk assessment completed by facility nursing staff on 11/28/12 identified this resident as being at high risk for falls.

On 01/08/13 at 6:00 a.m. on the facility's SCU, Resident #95 was observed seated near the nurses' station. One large [REDACTED] area was visible on his [REDACTED] and a second one on the back of his [REDACTED] over the knuckle of his second finger. Review of the resident's medical

F 323

changes in status including changes to the resident environment and equipment that require an overall safety evaluation. All accidents and incidents are also reviewed daily at the stand-up meeting.

Alarm monitoring forms are being forwarded to the QAPI committee quarterly and the Director of Nursing shall validate ongoing compliance.

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F 323	<p>Continued From page 19</p> <p>record found he had exited the SCU through a door which was to be secured with an alarm on the morning of 01/01/13, and was later found outside at 6:15 a.m. by staff. Staff documented when he was found outside he was lying on a concrete patio by the door. He was dressed in cotton pajama pants, a gown and slipper socks. Staff described the resident, when found, as "cold, shivering, laying on his right side...". The resident was not able to respond verbally to staff and required the assistance of three staff to place him in a wheelchair and bring him inside. His initial vital signs, as documented by nursing staff, included a temperature of 94.7 degrees Fahrenheit (F).</p> <p>Review of the facility's investigation of this resident's injuries revealed during night shift on 01/01/13, he had attempted to go outside through the exit door located in the SCU dining room at approximately 4:30 a.m. Staff documented Resident #95 exited the dining room to a fenced patio again at 5:30 a.m. and needed to be persuaded by a nursing assistant (Staff L) to come back inside. The outdoor air temperature in the Issaquah area on the night of 01/01/13 was below freezing (27 to 30 degrees F). Staff documented on both of these occasions, an alarm on the door did sound to alert staff someone had opened the door. Statements made by night shift staff as part of the investigation included a sentence that a staff member locked the door after Resident #95 returned inside.</p> <p>During initial rounds by a member of the day shift staff (Staff N) on 01/01/13 at 6:13 a.m., the staff member was not able to locate Resident #95 and started searching for him. He was reportedly</p>
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found outside at 6:15 a.m., on the ground near the entry door, shivering, with abrasions on his leg and elbow and a skin tear on his right hand. He did not have his walker, which was found in the dining room. The facility's investigation concluded the staff member may not have "fully engaged" the alarm (to turn it on) after Resident #95 was escorted back inside around 5:30 that morning. According to this investigation, facility staff concluded when he later exited the building through the same door, the alarm did not sound to alert staff he had again gone outdoors. Two Nursing Assistants on duty during night shift on 01/01/13 (Staff L and Staff M) provided written statements as part of the investigation which indicated the resident had last been seen in bed around 5:55 a.m.

On 01/09/13 at 10:45 a.m., during an interview with the DNS (Staff B) and a corporate consultant (Staff H), the facility's investigation of this incident was reviewed. Staff H stated she believed the resident was being supervised since he was reportedly found outside 20 minutes after he was last seen. The facility's conclusion that the resident exited because the alarm was not fully engaged to alert staff of Resident #95's departure was also discussed.

During the exit conference on 01/09/13 at 1:30 p.m., the facility Administrator (Staff A) stressed that the recording of the resident's temperature at 94.7 degrees was an axillary temperature and therefore did not indicate a significantly lowered body temperature. There was no indication in the resident's record or in the investigation that the temperature was axillary and not oral. According to the National Institutes of Health, while an

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F 323	<p>Continued From page 21</p> <p>axillary temperature is typically one half to one degree lower than an oral temperature, the resident exhibited a lower than normal body temperature regardless of which method was used.</p> <p>Failure by the facility to provide supervision for Resident #95 when he was outdoors (as specified in his care plan) resulted in this resident going outside in cold weather and falling. The lack of supervision resulted in the resident walking outdoors without his walker, then falling and sustaining several abrasions which were still present a week later. Additionally, without staff supervision, he was allowed to be outdoors without suitable warm clothing or footwear or monitoring of his physical safety, resulting in an abnormally low body temperature, placing him at risk for hypothermia. Failure to ensure staff correctly and effectively engaged the alarm system intended to alert staff when residents exited the building, placed Resident #95, and other residents of the SCU with a history of exit seeking, at risk for harm.</p>	F 323		
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 by: Based on observation and interview it was determined the facility failed to ensure residents</p>	F 364	<p>F364 Nutritive Value/Appear, Palatable/Prefer Temp</p> <p>Resident's #212 and 217 no longer reside at the facility.</p> <p>Residents #62, 12, 52 and 61 have been interviewed by the dietary manager to identify and address any food concerns. All identified residents are receiving food that is palatable, attractive and at the proper temperature.</p> <p>All other interviewable residents have been interviewed to identify food concerns. Any identified concerns have been referred to</p>	2/25/13

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NAME OF PROVIDER OR SUPPLIER ISSAQUAH NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 805 FRONT STREET ISSAQUAH, WA 98027		
(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 364	<p>Continued From page 22</p> <p>received food that was served at appropriate temperatures and consistency to maintain food quality and palatability. Six (#'s 62, 12, 52, 61, 212 & 217) of the 16 residents interviewed during Stage 1 and one (#65) additional resident voiced concerns about the temperature, taste, or look of the food served. These failures placed all residents at risk for decreased quality of life, compromised nutritional status, and possible weight loss.</p> <p>Findings include:</p> <p>During interviews in Stage 1, residents expressed a variety of concerns related to the food served. For example, on 01/04/13 at 10:19 a.m., Resident #62 stated "very seldom does it (food) come at the right temperature." He further explained he "almost always have to send it back to get heated." He also noted, "vegetables are usually almost always over cooked." Resident #12 in an interview on 01/04/13 at 8:12 a.m. stated recently the food was not "tasty". Resident #52, in an interview on 01/04/13 at 9:46 a.m., stated food did not always arrive at the proper temperature. On 01/04/13 at 10:00 a.m., Resident #61 stated she was frequently served food she had not requested. "They give you what they want and not what you ask for. I don't like certain things so of course it doesn't look good if I don't like it." She further explained she was served biscuits and gravy that morning although she requested the alternate and had told staff she did not like gravy.</p> <p>Observations were made on 01/03/13 of the Unit 200 Hall trays. The trays were scheduled for noon and arrived at 12:10 p.m. Staff P arrived at 12:22 p.m. and began to distribute the trays. At 12:29</p>	F 364	<p>the dietary manager through the facility grievance process for resolution.</p> <p>The facility has established a resident dining committee to review menus, identify dining issues and make recommendations for improvement.</p> <p>Facility managers are completing daily dining observations to assure food is palatable, attractive and served at the proper temperature.</p> <p>Dining observation reports are being forwarded to the facility administrator through the QAPI committee for tracking, trending and analysis.</p> <p>The facility administrator will validate ongoing compliance.</p> <p>Compliance Date: 2/25/2013</p>		

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F 364	<p>Continued From page 23</p> <p>p.m. Staff Q arrived to assist. At 12:42 p.m. Staff P served the second to the last tray. One tray remained for Resident #76 who, according to Staff P, required staff to use a hooyer lift to get her up in her chair, so she could eat. Staff P and Q were observed to assist Resident #76 to get up out of bed and seated at a bedside table. The resident's tray was served, without benefit of reheating, at 1:05 p.m., 55 minutes after the trays arrived on the unit. Both of the staff indicated the prior observations were routine and it typically took about an hour to pass the room trays completely.</p> <p>A test tray was requested on 01/07/13. The tray cart arrived on the 200 Unit hall at 12:10 p.m. At 12:23 p.m. two nursing assistants passed the trays and served coffee off the cart at the same time, five trays were observed still on the cart, including Resident #62's. Excluding Resident #76's tray, the last tray was served at 12:28 p.m. at which time the test tray was assessed. The pork was 114 degrees Fahrenheit (F), the pureed pasta measured 116 degrees F, and the spinach was 108 degrees F. The milk was between 43 to 44 degrees F.</p> <p>In interviews on 01/07/13 at 12:36 p.m., Resident #62 and Resident #65 both indicated their food was not hot. Resident #65 commented, "feel the plate, it's luke warm, here" (sticking her finger on the pork), "this isn't warm at all." Resident #12 said spinach was cold and unseasoned, "I like spinach, but this has no butter, no salt...".</p> <p>An additional test tray was requested on 01/08/13. The tray was delivered to the 200 hall at 12:11 p.m. and staff began to serve residents</p>	F 364		

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F 364	Continued From page 24 in their rooms at 12:14 p.m. At 12:27 p.m., after the last resident was served, with the exception of Resident #76, temperatures and consistency were assessed. The mixed vegetables were lukewarm, limp and soggy. The rice and lentils was dry and tasted "starchy", with no discernable seasoning. The milk was 52.7 degrees F and was not cold to drink. Residents were then asked about the meal. Resident #12 stated, "It tastes awful" and pointed to the rice with lentils. Resident #65 reported the food on his plate was "still cold, lukewarm". Resident #62 stated the meal "could have been warmer." He also stated he did not like rice and so he could not state whether the rice with lentils he was served was the proper temperature. Review of Resident #62's food preference sheet revealed a dislike of rice and beans. In an interview on 01/09/13 at 11:08 a.m., Resident #62 stated, "I don't eat rice except for fried rice... yeah, they gave it to me yesterday, I just don't eat it...". The resident indicated he would have preferred mashed potatoes and gravy which he would have eaten.	F 364		
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 458	F458 Bedrooms Measure at Least 80 SQ FT/Resident The facility has applied for a waiver.	

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F 458 Continued From page 25
review, the facility failed to provide 80 square feet of space per resident in 28 of 63 resident rooms which are licensed as multi-bed rooms.

Findings include:

According to facility documentation and observation, the following rooms measured less than 80 square feet (sq ft.) per resident, according to their licensed capacity:

300 Unit:
Four 2-bed rooms (#300, 301, 302, 303) measured 154 sq. ft., or 77 sq. ft. per resident.
Six 2-bed rooms (#304, 305, 306, 307, 308 and 309) measured 157 sq. ft., or 78 sq. ft. per resident.
One 3-bed room (#312) measured 233 sq. ft., or 77.66 sq ft. per resident.
One 3-bed room (#314) measured 216 sq. ft., or 72 sq. ft. per resident.
Five 3-bed rooms (#313, 315, 316, 319 and 320) measured 225 sq. ft., or 75 sq. ft. per resident.

400 Unit:
Five 3-bed rooms (403, 405, 406, 407 and 408) measured 225 sq. ft., or 75 sq. ft. per resident.
Six 3-bed rooms (400, 401, 402, 404, 409 and 410) measured 230 sq. ft., or 76.5 sq. ft. per resident.

Additionally, two rooms currently in use for other purposes (Admissions Office and Special Care Unit Activity room) were included in the certified/licensed bed capacity and would require waivers if they became resident rooms.

During the survey, there were no observed/

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F 458 Continued From page 26
reported problems affecting resident care due to the space available in these rooms. On 01/03/13 at 10:25 a.m., the presence of undersized rooms was discussed with the facility's Administrator, who stated a waiver would be requested for the rooms with less than the required square footage.

F 458