

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

PRINTED: 01/22/2014
FORM APPROVED
OMB NO. 0938-0391

1411

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505322	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/23/2013
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NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES-SPO	STREET ADDRESS, CITY, STATE, ZIP CODE NORTH 6025 ASSEMBLY SPOKANE, WA 99205
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Manor Care Health Services-Spokane on 9/17/13, 9/18/13, 9/19/13, 9/20/13, and 9/23/13. A sample of 36 residents was selected from a census of 92. The sample included 34 current residents, and the records of 2 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>██████████ R.N., B.S.N. ██████████ R.N., B.S.N. ██████████ R.N., B.S.N. ██████████ R.N., B.S.N. ██████████ R.N., M.S.N. ██████████ R.N., M.N.</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging and Long-Term Support Administration (AL TSA) Division of Residential Care Services, District 1, Unit A 316 West Boone Avenue, Suite 170 Spokane, Washington 99201-2351</p> <p>Telephone: (509)323-7303 Fax: (509) 329-3993</p> <p><i>Residential Care Services</i> Date 1/23/14</p>	F 000	IDR AMENDED	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to keep personal information confidential related to 3 of 34 current and/or former residents identified with the results of the last standard survey. Findings include:</p>	F 164		10/29/13

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F 164	Continued From page 2 During an environmental tour on 9/19/13 at 1:25 p.m., the results of the last standard survey was located in a notebook on a lamp table in the entrance, accessible to residents and visitors. Included with the results of the survey was the list of 30 current and 4 former residents identified by name and number. The results of the survey included information about 3 of the identified residents, including medical information and services provided by the facility.	F 164		
F 226 SS=D	In an interview on 9/23/13 at 3:00 p.m., Staff #B confirmed the resident list should not have been made available with the survey results. 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to implement their policies/procedures for the reporting and/or conducting thorough investigations of alleged abuse involving 1 of 2 (#215) residents reviewed for abuse in a sample of 29. Findings include: Review of the facility procedure for abuse and neglect prevention included a clear description of who staff should report abuse allegations to. During an interview with Resident #215 on 09/17/2013 at 2:54 p.m., the resident reported a	F 226		10/29/13

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F 226	Continued From page 3 concern about her shower that morning. The resident alleged abuse and said this was upsetting to her and she told a licensed nurse after the shower. During interview on 9/19/13 at 1:30 p.m., Staff #J, who showered the resident on 9/17/13, stated the resident became upset and didn't want to be showered after the shower started. Staff #J said she finished quickly then returned the resident to bed. During interview on 9/23/13 at 1:05 p.m. Staff #A and Staff #B stated Staff #I and #J (licensed nurse) did not immediately report the resident's concerns to facility administration so the resident could be interviewed timely and measures to protect her could be implemented if needed. Staff #B confirmed facility staff did not follow the proper facility procedure for abuse prevention.	F 226		
F 241 SS=D	See F242 for additional details. 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to promote care for residents in a manner that maintained or enhanced the dignity for 2 of 5 residents(#130, #235) related to dining. Findings include:	F 241		10/29/13

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F 241	Continued From page 4 On 9/23/13 at 11:30 a.m., the food holding cart was in main dining room and residents were seated at tables. At 11:32 a.m., Resident #235 had his tray placed in front of him, lid removed. His table mate Resident #130 was also served her tray, lid removed. At 11:45 a.m., Staff #G said to Staff #F from across the room " Those two at that table are both full feeders ", referring to Residents #130 and #235. Resident #130 was observed lifting an empty fork to her mouth several times. At 11:50 a.m., Staff #F started to assist Resident #235 to eat 18 minutes after his tray was placed in front of him. Again Staff #F asked how he ate and Staff #G stated he is really new and he is a complete feeder. At 11:52 a.m., after only 3 bites Resident #235 stated he wanted to leave the dining room. At 11:54 a.m., Staff #G stated to Resident #130 "This is set up all wrong you can't eat if it is set up like this." Staff #G proceeded to assist and cue Resident #130 while standing next to her, 23 minutes after her tray was placed in front of her. Per interview on 9/23/13 at 12:06 p.m., Staff #F stated it is not normal practice to call residents " feeders " . The facility failed to give the resident's a dignified dining experience.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.	F 242		10/29/13

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F 242	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to consistently honor individual choices for 2 of 3 residents (#215, #233) in a sample of 29 related to showers and time for getting up in the morning. Findings Include:	F 242			
	<p>1. Per record review, Resident #215 had no memory problems and required total assistance with bathing. The care plan directed the staff to assist the resident with a bath/shower as needed and did not include information about resident bathing choices. In an interview on 9/17/2013 at 2:54 p.m., the resident stated she did not like to take a shower because she didn't like water sprayed on her face. The resident stated earlier that day she refused a shower from Staff #J. She then agreed to the shower but became upset during the shower due to worry about water on her face. During an interview on 9/23/13 at 1:05 p.m., Staff #A and #B stated when the resident initially refused the shower, staff did not honor the choice to refuse and explore measures to ensure comfort with bathing.</p> <p>2. Resident #233, per record review, admitted to the facility for rehabilitation following a [REDACTED]. She had memory problems and required extensive assistance with activities of daily living (ADL's). During an interview with the resident's daughter on 9/18/13 at 9:45 a.m., she stated her mother usually got up around 10:00 a.m. She</p>				

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F 242	Continued From page 6 reported her mother got up in the facility around 6:30 a.m. so she could be ready for breakfast at 7:00 a.m. The resident and her daughter thought she had to get up early because she required assistance with eating. On 9/19/13 at 2:15 p.m., Staff #T and #U reported they didn't know the resident wanted to sleep in. They reported she had oral exercises and needed assist with meals. On 9/23/13 at 9:58 a.m., Staff #V reported the residents were asked preferences by his staff and does not pass the information along to the other disciplines. On 9/23/13 at 10:11 a.m., Staff #W said the resident required assistance with dining and would probably have to miss breakfast or have alternate meal times. On 9/23/13 at 10:54 a.m., Staff #F said she would not ask the resident if they wanted to sleep in. The facility failed to have a system in place to ensure that resident's choices were honored.	F 242		
F 257 SS=B	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that 1 of 2 dining rooms was maintained at a comfortable temperature for the residents. Findings include:	F 257		10/29/13

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F 257	Continued From page 7 On 9/18/13 in the main dining room (DR)during and following the noon meal, 8 to10 residents complained the room was too cold, the air vents were blowing air down on them, they were chilled and that it was always cold in the DR. Residents further commented they had to wear coats, sweaters and use blankets to keep them warm during meal times. Following the noon meal, the temperature of the dining room was taken by Staff #E. Depending on the location in the dining room, the room temperature measured 68-72 degrees. He validated that the dining room was chilly, more so in certain locations of the dining room.	F 257		
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).	F 279		10/29/13

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F 279	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop comprehensive care plans for 4 of 24 sampled residents(#11, 63, 79, 215, 229) related to unnecessary medications and pain management. Findings include:</p> <p>Unnecessary Medications</p> <p>1. Resident #11 was admitted on [REDACTED]/2013 with diagnoses including [REDACTED]. Per review of the medication administration for September 1st thru 16th, the resident received a medication for [REDACTED] 16 times. Per record review on 9/23/13 no active plan of care for non pharmacological interventions related to [REDACTED] was found for resident. Per interview on 9/23/13 at 1:00 p.m., Staff #C and Staff #D confirmed there was no care plan for [REDACTED] for Resident #11.</p> <p>2. Resident #63, per record review, had diagnoses that included [REDACTED] and [REDACTED]. Per record review, the resident had a physician's order on 8/21/13 for an anxiety medication to be given as needed up to 4 hours per day. The resident received 9 doses from 9/1/13-9/11/13 (out of a possible 44). On 9/11/13 the order for the anxiety medication was changed to be given routinely four times a day. Per review of the resident's plan of care, there was no active care plan for monitoring, effectiveness of medication or non-pharmacological interventions related to the use of an anxiety medication. During an interview on 9/23/13 at 1:00 p.m.,</p>	F 279		
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F 279	<p>Continued From page 9</p> <p>Staff #C and Staff #D confirmed there was no care plan for anxiety for this resident.</p> <p>3. Resident #229, per record review, had chronic [REDACTED] health concerns and [REDACTED]. The resident was on an anti-anxiety medication 3 times daily as needed.</p> <p>On 9/21/13 at 10:23 a.m., Staff #W reported the resident got anxious when she got short of breath.</p> <p>On 9/23/13 at 1:54 p.m., the resident reported she was having a panic attack. She reported medications helped or laying down. Staff #U reported she let the nurse know, but there was nothing else she was directed to initiate.</p> <p>On 9/23/13 at 1:56 p.m, Staff #Y gave her an as needed anti-anxiety medication and reported the facility was adjusting her medications to what she took at home. She said the staff also try diversional activities as was more anxious when her husband was not with her.</p> <p>On 9/23/13 at 2:01 p.m., Staff #X reported the resident had anxiety. She said the resident's husband visited quite a bit, and staff invited the resident to activities. She reported nothing really alleviated the resident's anxiety, except for the resident's husband.</p> <p>On 9/23/13 at 2:14 p.m., Staff #D reported there should be interventions addressed on the care plan to help manage her anxiety.</p> <p>Pain Management</p> <p>4. Resident #79, per record review, had chronic [REDACTED] and [REDACTED].</p> <p>The resident was on a narcotic pain patch, non-narcotic pain patch, scheduled/as needed narcotic pain pills, and muscle relaxers for pain.</p>	F 279		

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F 279	Continued From page 10 Per the pain assessment on [REDACTED]/13 (the day she admitted to the facility), the resident described her pain as aching, throbbing, stabbing, and hurting all over. The pain was exacerbated by position changes and eating. The facility was aware the resident had pain issues and failed to develop a comprehensive, individualized plan of care to address these issues, which placed the resident at risk for ongoing and worsening pain.	F 279		
F 282 SS=D	5. Resident #229, per record review had [REDACTED] disease and [REDACTED]. On 9/18/13 at 9:24 a.m., the resident rated her pain at "4" out of 10 (10 being the worst pain) and reported she used a heating pad and took aspirin at home for pain. There was no individualized care plan written for pain or developing the interventions that were effective at home. On 9/21/13 at 10:23 a.m., Staff #W reported the facility procedure was for staff to complete a pain assessment and the manager develops the care plan. The facility was aware the resident had pain issues and failed to develop a comprehensive, individualized plan of care to address these issues, which placed the resident at risk for ongoing and worsening pain. 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		10/29/13

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F 282	<p>Continued From page 11</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to consistently implement planned interventions for 1 of 24 sample residents (#65) in accordance with the resident's comprehensive care plan related to respiratory care and wound management. Findings include:</p> <p>Resident #65 had diagnoses including [REDACTED], [REDACTED], and [REDACTED] problems. Per record review, the resident had memory problems and required extensive to total assistance for activities of daily living. The resident's health had been declining and was placed on palliative/comfort care 9/5/13. The resident was non-interviewable.</p> <p>Respiratory Care:</p> <p>Resident #65 was observed daily throughout the survey to have oxygen on at 1-3 liters per a nasal cannula (nc). Per record review, the physician ordered oxygen related to shortness of breath on 7/25/13 for 1-4 liters via nc to keep oxygen saturation (a measure of how much oxygen is carried in the blood) greater than 90% and to monitor oxygen saturations two times daily. Per review of the September 2013 treatment administration record (TAR), the oxygen saturation levels were not documented as done 16 of 44 times. Further, licensed staff was not documenting whether oxygen saturations were done or how many liters the resident was on. In reviewing the September 2013 physician orders, the order for oxygen at 1-4 liters had been crossed out and hand written in was oxygen at 3</p>	F 282		

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F 282	<p>Continued From page 12</p> <p>liters per nc as needed to keep sats above 90% (no order date and/or discontinuation of prior order).</p> <p>On 9/19/13 at 3:30 p.m., Staff #L stated there was confusion with the oxygen orders and not sure why the order was changed. Staff #L went into the resident's room and verified the resident was receiving 2 liters and not 3 liters of oxygen per nc. The licensed nurse verified the oxygen orders were unclear, the hand written order at 3 liters had not been transcribed on the TAR, licensed staff were not documenting oxygen liter flow and/or completing oxygen saturations as ordered. The licensed nurse clarified the order and a new physician order was written for oxygen at 3 liters to keep oxygen saturation above 90%. The resident was sleeping and in no apparent respiratory distress.</p> <p>On 9/20/13, Staff #C verified the oxygen saturations were not done as ordered and there was confusion surrounding the oxygen order. The licensed nurse again clarified the oxygen order and the physician order was changed to 1 liter.</p> <p>On 9/23/13 at 8:20 a.m., Staff #C was feeding the resident breakfast. The resident was awake, alert, on oxygen at 3 liters per nc and in no apparent respiratory distress. Staff #C verified the resident's oxygen was set at 3 liters and she was unsure why because the order had been changed to 1 liter.</p> <p>Upon further review of the September TAR, the licensed staff were completing the oxygen saturations two times daily as ordered from 9/19/13, but were infusing 1-3 liters of oxygen with saturation levels of 96-98%. There was no documentation to support whether the resident had and/or was experiencing respiratory difficulties causing the licensed staff to increase the resident's liter flow which was not in</p>	F 282	

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F 282	<p>Continued From page 13 accordance with the physician orders and/or care plan.</p> <p>Wound Management:</p> <p>Resident #65 was observed on all days of survey positioned in bed. Per review of the skin team assessment 9/16/13, the resident had a wound to the heel, measured 2.3cm x 1.5cm, eschar (black) tissue with no drainage. The plan was to continue the treatment as ordered, reposition the resident and float the heels (no direct contact). The resident required extensive to total assistance from staff for positioning and bed mobility.</p> <p>On 9/19/13 at 9:20 a.m., the resident was lying in bed, positioned on her back with both heels positioned directly on the mattress. The heels were not floated per the care plan. At 10:05 a.m., Staff #O provided care to the resident. The resident was turned to her side exposing the heel wound. The wound was open to air, oozing bloody drainage onto the sheet and parts of the black tissue from the wound had been pulled away from the skin. The nursing assistant completed care, positioned resident and floated her heels. At 3:10 p.m., the resident was positioned on her side with the heel positioned directly on a pillow oozing bloody drainage.</p> <p>On 9/20/13 at 8:45 a.m., the resident was lying in bed, positioned on her back with a pillow positioned under her knees, both heels were positioned directly on the mattress. At 9:50 a.m., the resident remained in the same position. At 10:10 a.m., Staff #N observed the resident and verified the heels were not floated and were resting on the mattress. The licensed nurse repositioned and floated the resident's heels.</p>	F 282		
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F 282	Continued From page 14 On 9/23/13 at 8:40 a.m., Staff #O commented that he was aware of the wound on the heel, it had been there for awhile, knew to keep the pressure off the heels and float them. He further commented that the drainage was present pretty much everyday since they removed the dressing and the wound is just left open now. He did not feel the need to report the drainage because everyone was aware of it. Per interview with Staff #C on 9/23/13, she was not aware of the bloody drainage and the expectation was staff should notify the licensed nurse of any drainage and to make sure the heels are floated at all times.	F 282		
F 317 SS=D	The failure of the facility to consistently implement planned interventions placed the resident at risk for a further decline in her condition. 483.25(e)(1) NO REDUCTION IN ROM UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. This REQUIREMENT is not met as evidenced by: Based on observaton and record review, the facility did not deliver ROM per care plan for 1 of 1 sampled residents (#83). Resident #83 had diagnoses that included [REDACTED] stage [REDACTED] disease and [REDACTED]	F 317		10/29/13

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F 317	Continued From page 15 disease. The resident had memory impairment and impaired decision making. She required extensive to total assistance with activities of daily living. Per record review, an assessment dated 4/29/13 documented the resident had no impairment in movement/range of motion (ROM) of upper or lower extremities. An assessment dated 7/23/13 documented the resident had impairment on both sides of her upper and lower extremities.	F 317		
F 323 SS=E	Per observation throughout the survey, Resident #83 had her arms and legs curled up towards her body and both hands were curled inward. Per review of the plan of care, the staff was instructed to do restorative ROM. The resident was to have [redacted] and [redacted] hand exercises twice a day due to decreased ROM. Per review of the ROM flow sheet from 8/26/13-9/19/13, the resident inconsistently received ROM to her hands. The resident received ROM once a day for 11 days and received no ROM for 6 of the days. Documentation as to why the resident didn't receive her ROM had her refusing 2 times and "not applicable" the rest of the times. 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.	F 323		10/29/13

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F 323	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that the residents environment remained free of accident hazards related to unlocked and accessible cleaning agents to confused residents in 1 of 4 resident halls. Findings include: On 9/17/13 at 12:15 p.m., the Northwest "Hall Bath" door was open, the cupboard containing disinfectant cleaner was unlocked and open. There was no facility staff in the immediate area. Staff #K came down the hall and per surveyor request, closed and locked the door. Staff #K verified the room was to be locked at all times. Confused and wandering residents were in the area. On 9/20/13 at 10:55 a.m., Staff #K verified the shower room door should have been locked, the automatic lock was not working correctly, Staff #E was notified and fixed the lock. Failure to keep the door locked at all times placed residents at risk for potential injury/accidents related to the ingestion of cleaning agents.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a	F 325		10/29/13

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F 325	<p>Continued From page 17 nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to identify weight loss in a timely manner for 1 of 4 (#63) residents. This failure placed the resident at risk for unplanned weight loss. Findings include:</p> <p>Resident #63 was admitted to the facility on 8/9/13. Per record review, the resident needed encouragement/supervision with meals. Per record review, on 8/9/13 the resident weighed 140 pounds. On 8/22/13 the resident weighed 132 pounds (6.1% weight loss in 13 days). The resident experienced a weight loss and the facility did not identify the issue nor did they put interventions in place to prevent further loss in weight. Per record review, the initial nutritional assessment was dated 8/15/13. The resident had an albumin level of 2.4 (normal is 3.5-5. Lower than normal levels may indicate poor nutrition). The resident was noted to have a variable intake with an average of 48% at meals. Per review of the progress notes, there was no documentation about the resident's weight loss from 8/9/13 - 8/22/13. Per record review, the resident's weight on 9/13/13 was 135, which showed the resident started to gain weight and stabilize. However, there were no interventions put in place at the time of the weight loss. Per interview on 9/23/13 at 1:00 p.m., Staff #P stated she received alerts from staff if there was</p>	F 325		

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F 325	Continued From page 18 a resident with significant weight changes. She stated the resident wasn't on her alert list. On 9/23/13 at 1:00 p.m., Staff #C stated she reviewed weights in between the dietician visits and would alert the dietician if there was a weight loss. Staff #C confirmed the dietician was not alerted on this resident. Although an 11 pound weight loss (6.1%) was documented in the resident record, the facility failed to monitor the resident's weight as planned, failed to identify the potential weight loss and failed to put interventions in place in order to prevent further weight loss.	F 325		
F 329 SS=D	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 antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		10/29/13

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F 329	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined the facility failed to ensure that 3 of 5 residents (#63, 76, 79) in a sample of 29 were free of unnecessary medications related to adequate justification of use, use of non-pharmacologic interventions prior to the use of a medication, and consistent monitoring of the effectiveness of the medication. Findings include: 1. Resident #63 was admitted to the facility on [REDACTED]/13. The resident had diagnoses that included [REDACTED] and [REDACTED]. Per record review, the resident had a physician order on 8/21/13 for an anxiety medication to be given as needed up to every 4 hours. Review of the Medication Administration Record (MAR) from 9/1/13-9/11/13, the resident received 9 doses (out of a possible 40). Per review of the progress notes from 9/1/13 - 9/11/13, it was documented that the anxiety medication was effective when given as needed. Per record review, on 9/11/13 the resident had an order to discontinue the as needed anxiety medication and had a new order to take the medication routinely four times a day. There was no documentation of the resident having an increase of behaviors nor justification as to why the medication was increased. Per observation, on 9/19/13 at 3:20 p.m., Resident #63 was observed in her wheel chair near the nurses station. The resident was heard	F 329		

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F 329	<p>Continued From page 20</p> <p>saying she wanted to walk. She then attempted to stand up from the wheel chair several times and was told to sit back down by staff. One staff member stated "she is due for an [REDACTED]" and the resident was escorted to the medication cart to receive her medication.</p> <p>The resident's current plan of care was reviewed and there was no care plan initiated for the use of an anxiety medication.</p> <p>On 9/23/13 at 10:55 a.m., when asked about the types of behaviors the resident had, Staff #M stated the resident was on an anti-anxiety four times a day. She then replied the resident had severe anger issues and once she was started on the anti-anxiety medication, she was pleasant.</p> <p>During an interview on 9/23/13 at 11:50 a.m., Staff #C stated the resident had behaviors once in awhile. She stated the resident didn't have anger issues but had aggression that seemed to resolve once she was started on [REDACTED] (a medication for dementia). She stated the resident liked to take walks when she was having behaviors. Staff #C also went on to say she heard the nurses talking with the physician the day the medication was changed to routine. Staff had told the physician the resident was taking the anxiety medication anywhere from two to four times a day and so the physician changed the order to routine.</p> <p>Failure to justify increasing an anxiety medication placed the resident at risk for unnecessary medication use.</p> <p>3. Resident #79, per record review, had diagnoses of [REDACTED]. She was on daily medications at bedtime to assist her with sleep.</p>	F 329	

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F 329	Continued From page 21 Per record review, the staff were directed to reduce environmental noise/distractions to facilitate sleep. There was no monitoring of how long the resident was sleeping at night. On 9/23/13 at 10:40 a.m., Staff #W reported they did not complete sleep monitoring on everyone. She said the night nurse passed it on in report if they were not sleeping. On 9/23/13 at 11:02 a.m., Staff #F reported that social services updated the care plan for psychotropic medications and how many hours the residents slept at night. On 9/23/13 at 1:45 p.m., the resident reported she slept approximately 12 hours per night and didn't need anything because her pain medications knocked her out. She stated she had been on the sleeping medications for years and could go without it. On 9/23/13 at 2:09 p.m., Staff #D reported the nurses initiated the care plans and reported there had been staffing changes and wondered if that had changed. The facility failed to monitor the effectiveness of the medication.	F 329		
F 514 SS=D	483.75(l)(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		10/29/13

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F 514	Continued From page 22 services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure that the clinical record for 1 of 29 residents (#16) was complete and accurate. Findings include: Resident #16 was admitted to the facility on [REDACTED]/13 with a diagnoses that included a disease of the [REDACTED]. Per record review, on 5/14/13 it was documented that the resident was very anxious, appeared afraid and was grabbing arms of the staff members not wanting to let go. She was started on an anxiety medication which had good results. Per record review, there was no further documentation until [REDACTED]/13 when the resident was found to be without respirations, apical pulse, and her skin was cold and dry. Per interview on [REDACTED]/13 at 12:00 p.m., Staff #C and Staff #F where unable to recall the resident or the circumstances related to her death.	F 514			

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STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 505322	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	DATE SURVEY COMPLETE. 9/23/2013
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 253	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain a clean and sanitary environment in 2 of 2 medication rooms. Findings include:</p> <p>On 9/17/13 at 10:45 a.m. in the South Medication Room, the air vent located above the medication refrigerator was soiled with a buildup of dust/grime and in need of cleaning. On 9/17/13 at 11:10 a.m. in the North Medication Room, 1 of 2 air vents was soiled with a buildup of dust/grime and in need of cleaning. On 9/19/13 at 2:10 p.m., Staff #E stated the air vents were on a cleaning schedule but licensed staff need to be present while housekeeping staff clean the medication rooms and they are not always available, more of a hit and miss.</p> <p style="text-align: right;">IDR AMENDED</p>		

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

The above isolated deficiencies pose no actual harm to the residents