

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

1417
PRINTED: 09/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/16/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE ST JOSEPH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 17 EAST 8TH AVENUE SPOKANE, WA 99202	
(X4) ID PREFIX TAG F 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG F 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE 10/25/13
	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator and Extended Survey conducted at Providence St. Joseph Care Center on 9/3/13, 9/4/13, 9/5/13, 9/6/13, 9/9/13, 9/10/13, 9/11/13, 9/12/13, and 9/16/13. A sample of 57 residents was selected from a census of 114. The sample included 49 current residents and the records of 8 former/and or discharged residents.</p> <p>The survey was conducted by:</p> <p>██████, BSW ██████, RN ██████, RN ██████, RN</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Long Term Support Administration 316 W. Boone Avenue Suite #170 Spokane, WA 99201-2351</p> <p>Telephone: (509)323-7302 Fax: (509)329-9993</p> <p> Residential Care Services</p> <p>9/30/13 Date</p>		<p>This plan of correction constitutes my written allegation of compliance for the deficiencies cited.</p> <p>However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet established State and Federal Law.</p> <p>██████ Administrator</p> <p>RECEIVED OCT 11 2013 DSHS ADISA HCS SPOKANE WA</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE Administrator (X6) DATE 10/10/13

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 221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined, the facility failed to assess the use of a restraint (lap buddy) prior to implementation for 1 of 1 resident with a restraint (#357) in a sample of 57. This failure placed the resident at risk for injury, diminished quality of life and/or declining physical function.</p> <p>Findings include:</p> <p>Resident #357 was admitted to the facility 9/1/13 for [REDACTED] and [REDACTED]. The resident had diagnoses including [REDACTED] disease, [REDACTED], and [REDACTED].</p> <p>According to the 9/1/13 History and Physical performed at the facility, the resident was very confused and his conversation did not make sense. He had generalized weakness, was using a wheelchair, tried to get up frequently, and was a high fall risk.</p> <p>The resident experienced two non injury falls on 9/2/13. The plan after the second fall was to implement a lap buddy to aid in positioning.</p> <p>The resident was observed on 9/3/13 at 3:30 p.m. in a wheel chair in the hall with a lap buddy velcroed to the chair. A lap buddy is a foam device that rests on a person's lap and attaches to the wheel chair to prevent standing. The resident was pulling and fidgeting with the lap</p>	F 221	<p>1) How the nursing home will correct the deficiency as it relates to the resident:</p> <ul style="list-style-type: none"> Resident 357 is discharged <p>2) How the nursing home will act to protect residents in similar situations:</p> <ul style="list-style-type: none"> Audit conducted of nursing home residents classified as having a restraint to ensure evaluation, assessment, alternatives and consents are documented and in place <p>3) Measures the nursing home will take or systems it will alter to ensure that the problem does not recur:</p> <ul style="list-style-type: none"> Restraint policy reviewed and updated to include requirements for evaluation, assessment, risk/benefits, alternatives, and signed consents Nursing staff will receive training on requirements under F221 and updated Restraint policy

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F 221	<p>Continued From page 2</p> <p>buddy, he was unable to remove it. He had the device pulled up and it was actually perpendicular to his lap, but he was unable to remove the device from the chair and could not stand. At 4:00 p.m., the resident was in the hall in the wheel chair with the lap buddy in place. He pulled at the device and was not able to remove it.</p> <p>On 9/4/13 at 8:50 a.m., the resident was in the wheel chair in his room with the lap buddy in place. He fidgeted with the Velcro straps and was able to remove the device. He stood up, walked to bed and laid down. He remained in bed until 11:20 a.m., when he stood up and walked to the bathroom independently.</p> <p>Staff #J and O were interviewed on 9/9/13 at 2:45 p.m. They were unable to provide further information related to the assessment for the lap buddy.</p> <p>Staff #L and O were interviewed on 9/10/13 at 8:50 a.m. regarding the resident's lap buddy restraint. They thought the resident was able to take off the device. They were not aware there were times with the resident was unable to remove the device independently.</p> <p>The resident's assessment for the use of the lap buddy was not found in the medical record. The facility did not address how the use of the lap buddy would treat the resident's medical condition, the potential risks and benefits of using the device and/or alternatives to the use of the restraint. There was no evaluation as to whether the resident could remove the device. The facility did not use alternate interventions on an ongoing basis prior to the implementation of the lap buddy.</p> <p>According to the facility's July 2002 policy regarding restraints, the facility must evaluate a patient's ability to remove the restraint.</p>	F 221	<p>4) How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <ul style="list-style-type: none"> Nursing managers will monitor nursing staff for compliance with all elements of the Restraint policy Nursing managers, or designee, will conduct random chart audits on residents who triggered under restraints to ensure proper assessment and all documentation requirements are in place <p>5) Dates when corrective action will be completed:</p> <p>October 25, 2013</p> <p>6) The title of the person responsible to ensure correction:</p> <p> Administrator</p>		

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F 225 F 225 SS=E	Continued From page 3 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225 F 225			

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F 225	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to complete thorough investigations of medication errors for 5 of 23 investigations reviewed, 4 of 57 sample residents (#2,54,208, 324) were affected.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Resident #208 had diagnoses of [REDACTED] and [REDACTED] disease. The resident was taking as needed medication for pain, as well as a [REDACTED] (narcotic pain medication applied directly to the [REDACTED] which provides a continuous dose). The physician orders instructed staff to change the [REDACTED] every 72 hours. <p>Per the May 2013 record, the resident's [REDACTED] was replaced on [REDACTED] 13. On the morning of 5/16/13, the resident complained of not feeling well, being anxious and nauseated, had tingling of the extremities, and eventually experienced uncontrolled shaking/jerking. She was sent to the emergency room (ER), and was given a medication for the uncontrolled movements (which according to the record was minimally helpful), pain medication, and medication for anxiety. After the resident received the pain/anxiety medications, she stated she felt well (and her symptoms resolved). During the ER stay, the resident discovered that the [REDACTED] was not on. Diagnoses on the emergency room report included probable [REDACTED] and [REDACTED].</p> <p>The facility investigation of the incident was reviewed. The causal factor for the symptoms again identified that the [REDACTED] had fallen</p>	F 225	<p>1) How the nursing home will correct the deficiency as it relates to the resident:</p> <ul style="list-style-type: none"> Investigation report for discharged resident #208 re-opened and reviewed. Investigation updated to include resident and staff interviews, [REDACTED] placement timeline, r/o of drug diversion, summary of findings, conclusion, and Care Plan updates and actions taken to prevent reoccurrence Two investigation reports for resident #2 re-opened and reviewed: <u>Investigation #1</u> on 4/19/13 updated to include staff interviews, use of "5 Whys" to determine cause, summary, actions taken to prevent reoccurrence, and conclusion ruling out abuse or neglect of resident. <u>Investigation #2</u> on 3/17/13 updated to include the correct facts of the medication error ([REDACTED] was given instead of [REDACTED]), staff interviews, use of "5 Whys" to determine cause, summary, actions taken to prevent reoccurrence, and conclusion. 	
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F 225	<p>Continued From page 5</p> <p>off, and the resident had experienced possible drug [REDACTED]. The [REDACTED] was never located, and the resident was not able to identify when it came off. Per the report, the resident had experienced some itching and irritation from the [REDACTED] previously, and it was theorized the resident may have loosened the [REDACTED]. The investigation did not have any documentation to show the resident had been interviewed about the missing medication. In addition, there were no interviews with staff to determine how long the [REDACTED] had been missing, and why the [REDACTED] could not be found.</p> <p>When interviewed on 9/11/13 at approximately 3:30 p.m., Staff #L stated the facility policy was for staff to check placement of the [REDACTED] every shift - she stated that this was in response to a previous problem with drug diversion in the facility. The surveyor (who had previously reviewed the resident's record) informed Staff #L that checking placement of the patch had been added to the Medication Administration Record on 5/17/13 (the day after the resident returned from the emergency room). The facility did not complete a thorough investigation of the incident - to include ruling out drug diversion. The resident experienced probable [REDACTED] symptoms because she was not receiving the medication for an undetermined period of time.</p> <p>2. Per record review, Resident #2 was readmitted to the facility on [REDACTED]/13. She had medications including [REDACTED] (a blood thinning medication) [REDACTED] daily (alternating days). The medication was placed on the Medication Administration Record (MAR) and dated 4/28/13. The facility identified a medication error and initiated an investigation on 4/20/13. According to</p>	F 225	<ul style="list-style-type: none"> • Investigation report for resident #54 re-opened and reviewed. Investigation updated to include clarifying of physician orders and facts of the medication error, staff interviews, use of "5 Whys" to determine cause, review of MAR charting process, summary of findings, actions taken to prevent reoccurrence, and conclusion • Investigation report for resident #324 re-opened and reviewed. Investigation updated to include staff interviews, use of "5 Whys" to determine cause, r/o abuse or neglect, summary of findings, conclusion, Care Plan updates, and actions taken to prevent reoccurrence <p>2) How the nursing home will act to protect residents in similar situations:</p> <ul style="list-style-type: none"> • Significant medication error reports for last 3 months will be re-reviewed and updated if necessary <p>3) Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p>	

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F 225	<p>Continued From page 6</p> <p>the investigation, the wrong dose of [REDACTED] was given on 4/19/13.</p> <p>Staff #L and O were interviewed on 9/11/13 at 2:00 p.m. regarding the medication error. They stated the resident went to the doctor on 4/19/13 and the dose of the [REDACTED] was changed to [REDACTED] mg daily. The new order was added to the medication log, but the previous dosage was not discontinued. Therefore, the resident received [REDACTED] mg of [REDACTED] in error.</p> <p>The investigation did not include documentation to show staff involved were interviewed to determine causes of the error and did identify the documentation error regarding the date. Staff #L stated they knew what happened at time of investigation, but were not able to determine what happened when the investigation was reviewed with the surveyor on 9/11/13. The investigation did not rule out neglect of a significant medication error.</p> <p>Pain medication Per review of a 3/17/13 medication error investigation, Resident #2 received [REDACTED] (instant release) the mornings of 3/16, 17/13 instead of the physician ordered [REDACTED] (slow acting).</p> <p>The investigation did not include any documentation to show staff involved were interviewed to determine causes of the error or where the other medication came from.</p> <p>Staff member #V was interviewed on 9/12/13 regarding the medication error and the investigation. She identified the resident with an order for [REDACTED] (quick acting). The resident went to the hospital and was readmitted without an order for [REDACTED]. The practitioner was notified of the resident's pain and ordered a [REDACTED] medication to be given twice a</p>	F 225	<p>Managers will receive focus training on the elements of F225 to include requirements under Phase I and Phase II investigations to include determining the "why", witness (interview) statements, providing a summary of incident, a conclusion ruling out abuse or neglect, and a plan to prevent reoccurrence</p> <ul style="list-style-type: none"> Investigation and reporting policy reviewed to ensure compliant with DSHS Phase I & 2 investigation guidelines Investigation Checklist and tool created for managers to assist in the investigation process using "5 Whys" approach to determine cause of incident <p>4) How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <ul style="list-style-type: none"> Department managers will review significant medication errors with Administrator or designee to ensure they are complete, cause identified, and appropriate actions taken Significant medication errors and outcomes will be monitored though the Quality Committee 	

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F 225	<p>Continued From page 7 day.</p> <p>Upon further investigation after the surveyor inquired about the error, it was determined the actual medication error that occurred was [REDACTED] was given instead of [REDACTED] [REDACTED] was never given. The investigation that was initiated at the time of the error did not reflect the actual error that occurred.</p> <p>The investigation was not thorough to determine the actual medication error, how it happened, and did not rule out neglect or diversion.</p> <p>3. Resident #54 was admitted to the facility on [REDACTED]/13. The facility's medication error investigation dated 8/26/13 did not clearly identify the circumstances of the error. The investigation did not identify what happened and there were no interviews with the staff involved.</p> <p>Staff #O was interviewed 9/12/13 at 11:20 a.m. regarding the medication error. After review of the investigation and she commented she did not know if an error really had occurred.</p> <p>After Staff #O reviewed the resident's record she reported the resident was admitted on [REDACTED]/13 and had a physician's order to start aspirin on 8/25/13. The record also contained an order from the practitioner dated 8/13/13, which clarified the aspirin order and indicated it was not to start until 8/26/13. The licensed nurse wrote the order on the Medication Administration Record in the same box as the original order and did not discontinue the previous aspirin order that was scheduled to start 8/25/13. Therefore, the resident receive [REDACTED] and aspirin on the same day. She verified there was an error and said the [REDACTED] should have been stopped on 8/25/13 and the aspirin was not supposed to start until 8/26/13.</p>	F 225	<p>5) Dates when corrective action will be completed:</p> <p>October 25, 2013</p> <p>6) The title of the person responsible to ensure correction:</p> <p>[REDACTED] Administrator</p>		

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F 225	Continued From page 8 4. Per record review, Resident #324 was admitted for treatment of [REDACTED] problems. The resident was alert, oriented, and independent with set-up for most activities of daily living. The resident's August 2013 medication orders included [REDACTED] medications for nausea, itching, and pain. Review of the facility investigation dated 8/21/13 revealed a night shift licensed nurse administered the wrong dose of [REDACTED] nausea medication. The medication order was for [REDACTED] milligrams (mg) every 6 hours as needed. The medication dosage could be repeated 1 time for a total of [REDACTED] mg. On 8/21/13 at 5:15 a.m., the licensed nurse gave [REDACTED] mg at one time (double the maximum dosage ordered). There was no information in the investigation regarding contributing factors to the cause of the error. In an interview on 9/9/13 at 3:45 p.m., Staff #K, the Resident Care Manager, stated the pharmacist reviewed the resident's medication regimen but was unable to identify measures the facility took to protect the resident from future medication errors. 5. During the survey, an additional 17 medication error investigations that occurred from 7/1/13 to present were reviewed. Thirteen investigations did not identify the circumstances related to the errors, did not rule out possible neglect, and did not identify measures to protect residents from possible harm related to medication errors.	F 225		
F 241	483.15(a) DIGNITY AND RESPECT OF	F 241		

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F 241 SS=E	<p>Continued From page 9</p> <p>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, interview, and record review, it was determined the facility failed to provide dining services in a manner that promoted and enhanced resident dignity for 9 of 28 residents (#1, 6, 24, 69, 81, 131, 134, 163, 170) served in the Garden Level large dining room in a sample of 57. Failure to consistently promote dignity in dining services had the potential to negatively impact the residents' quality of life. Findings include:</p> <p>Per review of the posted seating chart, the Garden Level large dining room seated 28 residents. Lunch was served from 11:30 a.m. to 12:30 p.m.</p> <p>Per review of resident records and daily staff schedules, 5 nursing assistants were assigned to assist 9 residents, all of whom required extensive to total assistance to eat. The residents were not able to be interviewed due to their medical conditions.</p> <p>During observation of lunch service on 9/3/13 at 11:30 a.m. in the Garden Level large dining room, staff took residents' menu orders and served food from a steam table. Residents who could feed themselves with set-up and encouragement were</p>	F 241	<p>1) How the nursing home will correct the deficiency as it relates to the resident:</p> <ul style="list-style-type: none"> Residents #1, 6, 24, 69, 81, 131, 134, 163, and 170 care plans reviewed to ensure dining assistance, choices and placement preferences are identified <p>2) How the nursing home will act to protect residents in similar situations:</p> <ul style="list-style-type: none"> Dining room configuration and resident placement will be reviewed to ensure residents requiring assistance are served within acceptable timeframes

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/16/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE ST JOSEPH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 17 EAST 8TH AVENUE SPOKANE, WA 99202		
(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 241	<p>Continued From page 10</p> <p>served as they entered the dining room. Residents who required assistance were not offered food until designated staff were available to provide assistance.</p> <p>At 11:45 a.m., Resident #6 and #24 were seated at the same table. Resident #6 had a sippee cup in front of her. Resident #24 had no fluids and watched as other residents ate.</p> <p>At 12:05 p.m., Resident #163 and #134 were eating with assistance at an adjacent table. A staff member brought Resident #131 to the dining room, and interrupted Resident #163's meal by moving her aside so Resident #131 could be placed at the table.</p> <p>At 12:09 p.m., staff picked up menus for Resident #6, #24, and #131, served their food and assisted them to eat, after a wait of 25 minutes for #6 and #24.</p> <p>Resident #1, #69, #81, and #170 were brought to a table between 11:45 a.m. and 12:00 p.m. After arriving in the dining room, no staff stopped to greet or converse with them until 12:10 p.m., when their food was served, a wait of 10-25 minutes.</p> <p>During observation of lunch service on 9/6/13 from 11:45 a.m. to 12:40 p.m. the Garden Level large dining room, the following was observed.</p> <p>At 11:45 a.m., dietary staff and Staff #B were serving residents who could eat with set-up and encouragement.</p> <p>At 11:50 a.m., Staff #H brought Resident #134 and #163 to a table. Staff #H then served other residents. At 12:10 p.m., another resident, who could feed herself, was served and began eating, while Resident #134 and #163 were not served and watched her eat. At 12:20 p.m., Staff #H served and assisted the 2 residents, a wait of 30 minutes.</p>	F 241	<p>3) Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p> <ul style="list-style-type: none"> Facilitated meeting will be conducted between dietary and nursing departments to review outcome of annual survey on Garden Leven focusing on customer service and engagement, satisfaction, resident placement, staff to resident assignments, timing of service guidelines, dining room hours, and room configuration Dining Service Committees to review outcome of facilitated meeting between dietary and nursing and develop plans to implement recommendation 		

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F 241	<p>Continued From page 11</p> <p>At 11:45 a.m., Resident #6 and #24 were already seated at a table. The 2 residents sat with no staff greeting or conversing with them until 12:10 p.m., when a staff member moved Resident #6 to another table.</p> <p>At 12:27 p.m., a staff member offered Resident #6 fluids, brought the meal, left the food covered, and asked another staff member who should assist the resident with the meal. At 12:40 p.m., Staff #D fed Resident #6, a wait of 55 minutes.</p> <p>At 12:10 p.m., Resident #24 remained alone at the table with no food or fluids, watching other residents eat. At 12:33 p.m., Staff #E brought Resident #131 to the same table and assisted both residents to eat, a wait of 45 minutes for Resident #24.</p> <p>Between 11:50 a.m. and 12:00 p.m., Resident #170, #1, and #69 were brought to a table. At 12:15 p.m., a staff member assisted Resident #69. At 12:34 p.m., Staff #F assisted the remaining 2 residents, a wait of 30 and 40 minutes for those residents.</p> <p>At 12:40 p.m., 10 minutes after meal service usually ended, Staff #G brought Resident #81 to the dining room and assisted her to eat.</p> <p>During interviews after the meal, Staff #D, #E, #F, #G stated they were late to the meal because they were providing care to other assigned residents. Staff #D and #G stated they usually brought their residents to the dining room and assisted them between 12:00 p.m. and 12:15 p.m.</p> <p>In an interview on 9/10/13 at 10:30 a.m., the dietary manager stated a committee including administrative and nutrition staff evaluated dining services. She stated the Garden Level dining room meal service was extended from 30 to 60 minutes to accommodate the number of residents</p>	F 241	<p>4) How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <ul style="list-style-type: none"> Dining Service Committee plan will be reviewed through QA Committee and appropriate actions will be taken to maintain compliance <p>5) Dates when corrective actions will be completed:</p> <p>October 25, 2013</p> <p>6) The title of the person responsible to ensure correction:</p> <p>██████████ Administrator</p>	

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F 241	Continued From page 12 needing assistance. When the surveyor informed the dietary manager residents waited up to 55 minutes to eat, she stated the plan was to have each nursing assistant bring their residents together by 12:00 p.m. and then stay in the dining room and assist them. The facility's failure to serve and assist residents in a timely manner resulted in the residents having to watch other residents dine while they waited for extended periods of time.	F 241		
F 242 SS=E	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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to honor preferences related to bathing for 4 of 4 residents (#3, 255, 342, 343) reviewed for choices in a sample of 57. Findings include: 1. Resident #255 had a recent ● replacement and pressure ●. Per record review, the resident required extensive assistance with most activities of daily living including bathing. The resident was able to make decisions independently. Per the current plan of care, the resident was to receive two showers per week.	F 242		

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F 242	<p>Continued From page 13</p> <p>In an interview on 9/5/13 at 10:00 a.m., the resident stated he would like to have at least two showers a week but there's times he felt lucky to get one shower. He went on to state he went almost two weeks without a shower at one time, because the bath aide got reassigned to other duties. He said he didn't feel good if he went too long without a shower and that's why he wanted at least two a week.</p> <p>Per review of the bathing records for the months of July 2013 to the end of August 2013, the resident went up to 10 days without a shower (7/6/13-7/16/13 and 8/3/13-8/13/13).</p> <p>2. Per record review Resident #3 was alert/oriented, independent with decision making, and required assistance with bathing.</p> <p>The resident was interviewed on 9/4/13 at 10:15 a.m. He said he was allotted two showers a week but did not usually get them due to staffing issues. The resident said he usually got 1 shower a week, but missed a lot of showers due to short staffing or staff call ins. He commented that baths are the first thing to be cut if the facility was short staffed.</p> <p>Further discussion with the resident on 9/9/13 at 12:05 p.m. revealed the resident did not get showers on a regular basis twice a week. He had specific staff members that assisted him with bathing and those staff were not always available. The resident stated he sometimes soiled himself and he did not like to miss his showers. On 9/9/13 the resident's hair was oily and he had dry matter in the corner of his eyes.</p> <p>Per review of the bathing records for the months of July 2013 to September 2013, the resident went 10 days without a shower from 7/3-13/13. He went seven days without a shower on two occasions (7/16-23/13 and 8/27-9/3/13).</p>	F 242	<p>1) How the nursing home will correct the deficiency as it relates to the resident:</p> <ul style="list-style-type: none"> Resident 342 and 343 discharged Residents #3 and 255 Care Plans reviewed and updated to accurately reflect residents preference and choices related to bathing <p>2) How the nursing home will act to protect residents in similar situations:</p> <ul style="list-style-type: none"> Nursing Home resident Care Plans will be reviewed to ensure bathing preferences are individualized and accurately reflect resident preferences <p>3) Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p>

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F 242	Continued From page 14 3. Per record review, Resident #343 was alert/oriented and required assistance with bathing. According to the resident's care plan she was to receive two showers per week per her choice. The resident was interviewed on 9/4/13 at 9:50 a.m. and stated she usually got a bath once a week, she did not receive a shower. She said when she was home she showered daily and said she would like more than one a week. The resident was admitted to the facility [REDACTED]/13 and her bath records were reviewed. The resident went without a bath or shower for 6-7 days on two occasions in the month she had been in the facility ([REDACTED]/13 and [REDACTED]/13). The facility did not provide two showers a week per the resident's choice. 4. Per record review Resident #342 was alert/oriented and required assistance with bathing. The resident was admitted to the facility [REDACTED]/13 for [REDACTED] following [REDACTED]. According to the resident's plan of care, the resident was to receive showers once a week. The resident was interviewed on 9/4/13 at 9:10 a.m. and stated she was supposed to get showers twice a week. The resident stated she never got two showers a week because the shower aide was off of work for two months. The resident stated she would rather have two a week because she felt "grungy". She stated she did not turn down a shower when staff offered, even if she had visitors. Per review of the bathing records from admission until September 2013, the resident went six days without a shower on two occasions; [REDACTED]/13 and [REDACTED]/13.	F 242	<ul style="list-style-type: none"> All responsible staff will be informed of updated Care Plan for residents bathing preferences All staff will be in-serviced on the requirements under F 242 to include the importance of honoring residents rights/choices in bathing and alternatives available Facility protocol for covering direct care will be updated to ensure bath aid will not be pull first <p>4) How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <ul style="list-style-type: none"> Nursing Mangers, or designee, will perform random of audit bath logs to ensure bathing choices are being honored and schedules maintained Audit results and Resident Council Minutes will be reviewed as part of the QA Committee and appropriate actions will be taken to address negative results 		

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F 242 F 244 SS=E	<p>Continued From page 15</p> <p>The facility did not consistently honor the residents' preference of two showers per week. Residents went six to 10 days without a shower on occasion.</p> <p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION</p> <p>When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to respond to grievances expressed by the resident council group in a timely manner for 12 to 21 residents that attended the meetings in the last 12 months.</p> <p>Findings include:</p> <p>During the Resident Council President interview on 9/4/13 at 8:30 a.m., Resident #3 was asked if the facility responded to issues brought up in the Resident Council Meetings. He said some department heads ignored the concerns brought up by the Council and the concerns came up time and time again. Resident #3 stated no one in the facility had accountability, he tried to set a system up and the facility would not let him.</p> <p>Resident #3 stated the Council had repetitively reported concerns about residents not receiving ice water every shift and the strong laundry detergent used to wash residents' clothes caused</p>	F 242 F 244	<p>5) Dates when corrective actions will be completed:</p> <p>October 25, 2013</p> <p>The title of the person responsible to ensure correction:</p> <p>██████████ Administrator</p>

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F 244	<p>Continued From page 16</p> <p>holes in the clothing. He stated food concerns were brought up on occasion and the responses were directed toward the food meeting, not reported to the Council. Residents did not constantly attend both meetings, so they would not always know the response or lack of response to food complaints that were reported in Resident Council.</p> <p>Review of the monthly Resident Council minutes for the last year indicated the the residents expressed concerns regarding :</p> <ol style="list-style-type: none"> Fresh ice water not being passed every shift in February 2013. The facility notified the Council in March that policy was to refresh ice water every shift. The Council expressed concerns regarding not getting ice water in June 2013. The July minutes did not identify any follow-up information from the June meeting. The residents reported in July that water pitchers were not being filled every shift. The August minutes did not address the concern or follow-up expressed in July and the documentation reflected the residents were still not getting fresh water every shift. Laundry detergent that caused holes in the resident's clothing or ruined clothing was identified as concerns in July and August 2012. The facility did not address the laundry detergent concerns. Other concerns regarding the laundry detergent were identified in December 2012, January and March 2013. There was no further information in the Resident Council Minutes that addressed the resident's concerns regarding the commercial laundry detergent that was used. 	F 244	<p>1) How the nursing home will correct the deficiency as it relates to the resident:</p> <ul style="list-style-type: none"> Resident #3 - Resident Council [REDACTED] provided update and plans to address on-going issues with ice water pitchers, laundry detergent, and food <p>2) How the nursing home will act to protect residents in similar situations:</p> <ul style="list-style-type: none"> Facility will request exhaustive list of all unresolved grievances from Resident Council to be follow-up by department heads Responses to resident grievances will be brought forward verbally and in writing at Resident Council Meeting and captured on the Minutes Update and response plans for on-going concerns with ice water pictures, laundry detergents, and food will be presented at next Resident Council Meeting Complaint and Grievance policy and process reviewed and updated 	

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F 244 Continued From page 17
3. Staff #AA frequently attended the Resident Council meetings and was interviewed on 9/6/13. She stated resident concerns were forwarded the appropriate department for follow-up. Once the department addressed an issue, it was brought back to the residents. If an issue did not get addressed or continued to be a problem, the residents would include it in the following month's minutes. Staff #AA commented that often times the issues were addressed with an individual resident and responses were not addressed to the entire council.
Staff #AA was aware of the ongoing issues with the ice water and laundry. She commented she did not think there was anything that could be done about the laundry detergent or if the facility looked at/ tried alternate detergents. She was unsure if any information had been reported to the residents. Staff #AA stated the ice water concern had been forwarded to the nursing department and was unaware of the outcome.
The facility did not ensure action was taken regarding concerns expressed by the Resident Council in a timely manner and/or responses consistently provided to the council.

F 250 SS=D 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE
The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:

F 244 3) Measures the nursing home will take or systems it will alter to ensure that the problem does not recur:

- Managers and staff will receive additional training on the revised Complaint and Grievance policy to include the requirements to respond to grievances timely
- Resident Council will be informed of outcome to all grievances by next scheduled council meeting

4) How the nursing home plans to monitor its performance to make sure that solutions are sustained:

- Department managers, Administrator, and regional Compliance Manager will monitor grievance and report findings through the QA Committee
- Resident Council Minutes will be reviewed by the Administrator or designee for timeliness of response to resident complaints.

5) Dates when corrective actions will be completed:
October 25, 2013

6) The title of the person responsible to ensure correction:
██████████, Administrator

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F 250	<p>Continued From page 18</p> <p>Based on observation, interview and record review, it was determined the facility failed to provide medically related social services for 1 resident (#255), who was experiencing signs/symptoms of depression and difficulty with loss of independence in a sample of 57. This failure resulted in harm to this resident as evidenced by ongoing depression and difficulty adjusting. Findings include:</p> <p>Resident #255 was admitted to the facility on [REDACTED]/13 for [REDACTED] services and [REDACTED] care. Per record review, the resident required extensive assistance with most activities of daily living and had some signs/symptoms of [REDACTED]. The resident was able to make decisions independently and his memory was intact.</p> <p>Per an assessment dated 6/14/13, the resident had episodes of depression and hopelessness.</p> <p>Per nursing notes dated 7/9/13, the resident said "it has been very hard being here after living independently for so long."</p> <p>A nursing note dated 8/6/13, noted the resident cried on this date after a talk with the nurse about his physical limitations and the loss of his wife [REDACTED] years ago.</p> <p>An assessment dated 8/25/13 revealed the resident continued to have episodes of feeling down, depressed, and hopeless.</p> <p>On 9/3/13, nursing staff noted the resident said "his emotions are on the surface and he has a hard time not crying when having a normal conversation."</p> <p>The most recent plan of care did not identify the resident's assessed signs/symptoms of [REDACTED] or any interventions in place to assist the resident with working through these issues and assisting with adjustment to the facility and</p>	F 250	<p>1) How the nursing home will correct the deficiency as it relates to the resident:</p> <ul style="list-style-type: none"> Resident #255 assessed by Social Services for on-going signs and symptoms of [REDACTED] with loss of independence. Care plan updated to include interventions for symptoms of [REDACTED]. Resident #255 requested not to have a mental health referral. <p>2) How the nursing home will act to protect residents in similar situations:</p> <ul style="list-style-type: none"> Audit records on all current nursing home residents who triggered on the last MDS for depression to ensure they have been assessed by social services, interventions and Care Plan are appropriate 	

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F 250	Continued From page 19 recent loss of independence. In an interview on 9/10/13 at 1:00 p.m., Staff #J stated when the resident was first admitted (6/7/13) he would tear up constantly. Staff #J confirmed it was something that should have been referred to social services. At 1:10 p.m., Staff #Q said she did not get a referral from nursing about the resident's tearfulness and difficulty adjusting and there hadn't been any emotional support provided to the resident. At 1:25 p.m., the resident said he had periods when he was depressed since he was moved to the facility and said it had been very hard adjusting. On 9/11/13 at 12:55 p.m., Staff #R said she worked with the resident often and he was tearful at times but felt he was going through an adjustment period, he was used to being independent. The facility identified the resident was experiencing some mood and adjustment issues but did not provide support services to assist the resident with coping which resulted in delayed adjustment and decreased quality of life.	F 250	3) Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur: <ul style="list-style-type: none">All nursing staff will be in-serviced on the requirements under F Tag 250 to include recognizing signs and symptoms of depression and requirements for referring to Social Services or Pastoral Care for assessmentAll residents with depression will be identified and assessed by social services on a quarterly or as needed basis, and appropriate behavioral interventions will be put into place in the Care Plan 4) How the nursing home plans to monitor its performance to make sure that solutions are sustained: <ul style="list-style-type: none">Nurse managers or designee will perform random audits of nursing home residents with symptoms of depression to ensure social services needs are being assessed and appropriate interventions are in place	
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.	F 279	5) Dates when corrective action will be completed: October 25, 2013 6) The title of the person responsible to ensure correction: ██████████ Administrator	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/16/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE ST JOSEPH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 17 EAST 8TH AVENUE SPOKANE, WA 99202	
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F 279	<p>Continued From page 20</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to develop comprehensive plans of care for 4 residents (#62, 249, 370, 255) in a sample of 57, related to activities of daily living, nutrition, pain, pressure ulcers and unnecessary medications. Findings include:</p> <p>1. Resident #62 had diagnoses that included [REDACTED] and [REDACTED]. According to the record, the resident required extensive assistance with activities of daily living On 9/5/13 at 8:30 a.m. the resident was observed in bed with several days growth of facial hair. When questioned about the beard, he stated he, "... didn't particularly care for it." The resident was shaved by staff on 9/6/13. On 9/9/13 11:50 a.m. the resident was observed with multiple days of beard growth and did not appear to have been shaved since last week. When interviewed at the time of the observation, the resident verified he had not been shaved over the weekend (9/7/13 and 9/8/13), and stated he didn't get shaved as often as he</p>	F 279	<p>1) How the nursing home will correct the deficiency as it relates to the resident:</p> <ul style="list-style-type: none"> Resident #249 discharged Resident #370 discharged Resident #62, Care Plan reviewed and updated to include individualized ADL needs of the resident and his preference to be shaved daily. Resident #255, Care Plan reviewed and updated to include individualized interventions and goals addressing the management of leg pain <p>2) How the nursing home will act to protect residents in similar situations:</p> <ul style="list-style-type: none"> Audit of resident care plans focusing on; declining ADL's, mod/sever pain, pressure ulcer, and weight loss to ensure they are individualized and appropriate interventions and goals are in place 	

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F 279	<p>Continued From page 21</p> <p>liked.</p> <p>Additional observations of the resident unshaven were made on 9/10/13 and 9/11/13. Per record review, the resident was identified as having self care deficits and had a care plan in place. The care plan was not individualized and did not address the resident's desire to be shaved daily.</p> <p>2. Resident #249 was admitted to the facility on [REDACTED]/13 with an [REDACTED] requiring [REDACTED] repair. On admission, the resident had a [REDACTED] on his [REDACTED].</p> <p>On 4/18/13, the [REDACTED] was removed and an aircast [REDACTED] was placed - it was to be removed for showers and for range of motion exercises. Written instructions provided by the orthotic company at the time the [REDACTED] was placed included: "Watch for red areas that do not disappear within 30 minutes. This would indicate too much pressure and that an adjustment needs to be made. Blisters and/or skin breakdown is not acceptable." The care plan was not modified at the time to include this information, and there was no documentation to indicate this was being done. A review of the care plan at the time of the survey indicated the goal was for the resident's skin to remain intact and for the surgical incision to heal.</p> <p>A skin assessment on 4/26/13 (8 days after the [REDACTED] was removed) documented the following areas on the [REDACTED]: dried blister/pressure areas on the [REDACTED] and [REDACTED], as well as some scabs on the top of the [REDACTED]. Documentation from the hospital indicated the resident had scabs on the [REDACTED] of both [REDACTED] prior to admission to the facility.</p> <p>The care plan did not identify the scabbed areas to the [REDACTED]. Additionally, preventative</p>	F 279	<p>3) Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p> <ul style="list-style-type: none"> In-service for all clinical staff on the requirements under F279 to include an overview of the Care Plan Policy focusing on comprehensive assessment, high-risk areas, individualized approach, resident preferences, interventions, and measurable goals Care Plan Policy will be reviewed and updated if needed <p>4) How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <ul style="list-style-type: none"> Clinical managers or designee will randomly audit records of residents who triggered ADL, mod/severe pain, development of pressure ulcer, and weight change to ensure appropriate interventions are in place and staff are in compliance with policy <p>5) Dates when corrective actions will be completed: October 25, 2013</p> <p>6) The title of the person responsible to ensure correction: [REDACTED] Administrator</p>

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F 279	<p>Continued From page 22</p> <p>measure were not put in place as recommended by the company that provided the [REDACTED]. Once the resident developed blisters/pressure areas, the care plan was not modified to include interventions for healing the skin alterations.</p> <p>3. Resident #370 was admitted to the facility on [REDACTED]/13 with diagnoses of [REDACTED] and [REDACTED] surgery. He was also being treated for a [REDACTED] of the [REDACTED].</p> <p>Both the hospital record and Interdisciplinary Progress Notes (IPN) documented the resident was having frequent nausea and diarrhea. His appetite and fluid intake were poor, and he was at risk for weight loss.</p> <p>The resident's care plan was reviewed on [REDACTED]/13 (7 days after admission to the facility). Aside from the resident's name and date of admit, the care plan was blank. The facility failed to initiate a nutritional care plan on admission despite the fact the resident was at high risk for additional nutritional compromise and weight loss.</p> <p>4. Resident #256 had diagnoses of recent [REDACTED], recent [REDACTED], and [REDACTED]. The resident required extensive assistance with activities of daily living and was able to make decisions independently.</p> <p>Per pain assessment completed on admission [REDACTED]/13, the resident had pain related to [REDACTED] and a [REDACTED].</p> <p>Per nursing notes dated 8/9/13, the resident complained of pain and numbness of both of his [REDACTED].</p> <p>Per nursing notes dated [REDACTED]/13, the resident was sent to the emergency room secondary to pain in his [REDACTED] and was sent back to the</p>	F 279	

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F 279	Continued From page 23 facility with a diagnosis of a [REDACTED]. The most recent plan of care did not address any of the resident's pain issues and did not provide any interventions to address pain. The facility was aware the resident had pain issues and did not develop a comprehensive, individualized plan of care to address these issues, which placed the resident at risk for ongoing and worsening pain.	F 279	1) How the nursing home will correct the deficiency as it relates to the resident: <ul style="list-style-type: none"> Resident #354 discharged Resident #255, re-assessed for leg pain. Care and treatment plan updated to include individualized interventions for management of pain to include non-pharm approaches 	
F 309 SS=D	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, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure necessary care and services were provided for 1 of 3 residents (#255) reviewed for pain issues and 1 of 4 residents (#354) reviewed for skin conditions in a sample of 57. Findings include: 1. Per record review, Resident #354 was admitted [REDACTED]/13 for ongoing treatment of a serious [REDACTED]. During an interview on 9/4/13 at 1:00 p.m., the resident wore clean clothes and socks with no shoes. When asked about his care, the resident stated he was at the facility for an [REDACTED]. He pulled off the sock on	F 309	2) How the nursing home will act to protect residents in similar situations: <ul style="list-style-type: none"> Care and treatment plans of resident who triggered for mod/severe pain or skin condition will be reviewed to ensure appropriate treatments and interventions are in place 	

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F 309	<p>Continued From page 24</p> <p>his [redacted] foot to reveal peeling skin on the entire [redacted] of the foot. The resident stated his [redacted] foot was the same way and could not answer additional questions about his feet.</p> <p>Per record review, there was no evaluation or care plan for the resident's skin condition.</p> <p>On 9/5/13 at 12:35 p.m., the surveyor informed Staff #C about the resident's skin condition and requested an evaluation. Staff #C stated did not know the resident the resident had a problems with his feet.</p> <p>Review of a physician order dated 9/5/13 revealed an order for a podiatry consult to cut back [redacted] on the residents' feet. There was no evaluation and/or description of the resident's skin condition.</p> <p>On 9/10/13 at breakfast, the resident was observed with shoes and no socks.</p> <p>On 9/10/13 at 1:45 p.m., the surveyor reviewed the status of the resident's skin with Staff #J and #L.</p> <p>At 1:55 p.m., Staff #J stated she evaluated the resident's feet with the physician and determined the resident had a [redacted] on the [redacted] of both feet.</p> <p>Per review of the resident's skin condition evaluation dated 9/10/13, the skin on the entire [redacted] surface of both feet was cracked, peeling, and had an odor. The treatment plan included topical medication and wearing clean socks when wearing shoes.</p> <p>The lack of timely evaluation and implementation of treatment placed the resident at risk for a worsening skin condition.</p> <p>2. Resident #255 had diagnoses of a [redacted] [redacted], and a recent [redacted]. The resident required extensive assistance with activities of daily living and was able to make</p>	F 309	<p>3) Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p> <ul style="list-style-type: none"> • Skin and Pain Assessment policies will be reviewed and updated if appropriate • All clinical staff will be in-serviced on the requirements of F309 to include the policy requirements for documentation and proper assessment and treatment of pain and skin <p>4) How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <ul style="list-style-type: none"> • Random chart audits will be performed by nurse managers or designee for high-risk patients to ensure compliance with skin and pain assessment policy <p>5) Dates when corrective actions will be completed:</p> <p>October 25, 2013</p> <p>6) The title of the person responsible to ensure correction:</p> <p>[redacted] Administrator</p>	
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F 309	<p>Continued From page 25</p> <p>his needs known.</p> <p>Per the admission pain assessment dated 8/7/13, the resident had pain related to [redacted] and a [redacted] replacement. However, there were no interventions in the current plan of care to address pain.</p> <p>Nursing notes from 8/7/13 to 8/8/13 noted the resident periodically complained of pain in his [redacted] leg, foot and at times his [redacted] back. The resident refused pain medication most of the time and was very concerned with taking any medications at all. During this time frame, there was one documented instance that the resident was offered a non-medication intervention (ice or heat) to manage pain, but the resident declined.</p> <p>On 8/9/13, at 2:30 p.m., nursing noted the resident complained of pain in his [redacted] knee through his toes and stated his whole [redacted] leg was painful. The nurse noted the resident had a history of [redacted] and a referral to the hospitalist was made to evaluate.</p> <p>Later in the day on 8/9/13, a different nursing staff documented the resident had no complaints of pain and was no longer taking routine pain medication. There was no mention of the resident's earlier complaints of pain, or the fact that the resident no longer takes pain medication because he does not like to take pain medication.</p> <p>On 8/13/13, nursing noted the resident refused pain medications and when asked if he was having pain stated "my [redacted] leg hurts about a [redacted] if I move it ([redacted] being the most painful), but I do not want to take any pain meds." There was no documentation to show the resident was offered any other interventions (non-med) to help manage the pain.</p> <p>On 8/13/13, the resident was sent to the emergency room and returned the same day with a diagnosis of a [redacted]. The resident stated</p>	F 309	

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F 309	Continued From page 26 he was in pain but didn't want any pain medication. There was no documentation to show the resident's pain was evaluated nor was there a plan put in place to address the resident's pain in his [redacted] leg without medication intervention. There were no identified non-medication interventions initiated for this resident. In an interview on 9/5/13 at 10:30 a.m., the resident said his [redacted] leg was painful and he tried not to put a lot of stress on it. He also said he started taking [redacted] as needed for pain. In an interview on 9/10/13 at 9:05 a.m., Staff #J said there were non-medication interventions used in the facility such as repositioning, ice, distraction, and/or music therapy. Staff #J confirmed there was no re-evaluation of the resident's pain after he was diagnosed with the [redacted] and there was no plan of care with any of the non-medication interventions noted above to address his pain. In an interview on 9/10/13 at 9:15 a.m., the resident stated he hadn't tried any hot or cold on his [redacted] leg, or any other non-medication interventions. He said he didn't like to take pain medications. The facility identified the resident's pain on admission but did not develop a plan to address his pain. In addition, the resident developed new pain issues during his stay but he was not re-evaluated nor were non-med interventions put in place to help manage the pain, which placed the resident at risk for worsening pain and decreased quality of life.	F 309			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of	F 312			

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F 312	<p>Continued From page 27</p> <p>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: Based on observation, interview and record review, it was determined the facility failed to provide necessary grooming for 1 resident (#62), reviewed for activities of daily living in a sample of 57. Findings include:</p> <p>Resident #62 had diagnoses that included [REDACTED], [REDACTED] and [REDACTED]. According to the record, the resident was unable to carry out activities of daily living and required assistance.</p> <p>On 9/5/13 at 8:30 a.m. the resident was observed in bed with several days growth of facial hair. When questioned about the beard, he stated he, "... didn't particularly care for it." The resident was shaved on 9/6/13.</p> <p>On 9/9/13 11:50 a.m. the resident was observed with multiple days of beard growth and did not appear to have been shaved since last week. When interviewed at the time of the observation, the resident verified he had not been shaved over the weekend (9/7/13 and 9/8/13), and stated he didn't get shaved as often as he liked. The resident further stated he would shave everyday if he could.</p> <p>Additional observations of the resident unshaven were made on 9/10/13.</p> <p>On 9/11/13 at 10:20 a.m., the resident's facial hair was untrimmed and unkempt looking, the resident stated he would like to have it, "trimmed up a bit" but was not able to do it himself.</p> <p>The facility failed to shave the resident on a</p>	F 312	<p>1) How the nursing home will correct the deficiency as it relates to the resident:</p> <ul style="list-style-type: none"> Resident #62, Care Plan reviewed and updated to reflect individualized ADL needs of the resident to include his desire to be shaved daily. <p>2) How the nursing home will act to protect residents in similar situations:</p> <ul style="list-style-type: none"> See F 279 Residents will be reviewed to ensure that grooming and shaving preferences and needs are being met <p>3) Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p> <ul style="list-style-type: none"> See F 279 In-service provided to all clinical staff on requirements under F312 to include Care Plan policy/process as referenced under F 279 	

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F 312 F 314 SS=D	<p>Continued From page 28</p> <p>regular basis in order to maintain good grooming.</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure that 1 of 3 residents reviewed (#249), in a sample of 57, did not develop a pressure ulcer. Findings include:</p> <p>Resident #249 was admitted to the facility on [redacted]/13 with diagnoses of [redacted] with [redacted] repair and [redacted]. Per the record, the resident had a [redacted] on his [redacted] leg on admit. On 4/18/13, the [redacted] was removed and a [redacted] was placed - the order directed staff to remove the [redacted] to shower the resident and for range of motion exercises (the resident was non-weight bearing on the leg at that time). Written instructions provided by the orthotic company at the time the [redacted] was placed included: "Watch for red areas that do not disappear within 30 minutes. This would indicate too much pressure and that an adjustment needs to be made. Blisters and/or skin breakdown is not acceptable." Additionally, the facility was to call if</p>	F 312 F 314	<p>4) How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <ul style="list-style-type: none"> Nurse managers or designee will perform random audits of care plans to ensure they are individualized and addressing residents shaving and grooming preferences. <p>5) Dates when corrective actions will be completed: October 25, 2013</p> <p>6) The title of the person responsible to ensure correction: [redacted] Administrator</p>

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F 314	<p>Continued From page 29</p> <p>there were any problems with the fit of the device (to include skin breakdown) so adjustments could be made. The care plan was not modified at the time to include this information, and there was no documentation to indicate this was being done - the medication/treatment records and Interdisciplinary Progress Notes (IPN) from the date of admission to discharge were reviewed at the time of the survey.</p> <p>A skin assessment on 4/26/13 (8 days after the [redacted] was removed) documented the following areas on the [redacted] lower leg: dried blister/pressure areas:</p> <ul style="list-style-type: none"> - [redacted] ankle [redacted] centimeters (cm.) - [redacted] cm. anterior - 4 scabs top of [redacted] cm. <p>Further record review indicated the [redacted] scabs were present on admission. The treatment record directed nursing staff to complete a skin assessment weekly. No assessment was done on 5/10/13 as scheduled. The next skin assessment of these areas was done on 5/17/13 (20 days after their initial identification). Area 1 was a "dried blister - red" (no measurements). Areas 2 & 3 "blister remains." The last documentation on the skin condition sheet was on 5/24/13 - it did not specifically address the condition of areas 1-3, but rather and area on the [redacted] 2nd toe (which was now reddened and required treatment).</p> <p>Staff L was interviewed on 9/12/13 at 2:00 p.m. - she was not aware resident #249 had developed pressure areas/blisters from the [redacted]. She indicated the facility policy was to do weekly skin assessments, and document any skin alterations on a specific form.</p> <p>The facility failed to prevent the resident from developing pressure areas/blisters from the [redacted]. The care plan was not modified,</p>	F 314	<p>1) How the nursing home will correct the deficiency as it relates to the resident:</p> <ul style="list-style-type: none"> • Resident #249 discharged <p>2) How the nursing home will act to protect residents in similar situations:</p> <ul style="list-style-type: none"> • See F 279 • Care Plans on residents who triggered for development of pressure ulcer on last MDS will be reviewed and updated to ensure appropriate skin interventions and preventative measures are in place <p>3) Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p> <ul style="list-style-type: none"> • Facility skin assessment policy and processes will be reviewed and updated • All clinical staff will be in-serviced on the requirements under F314 to include updated facility skin assessment policy and processes 		

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F 314 F 325 SS=F	Continued From page 30 and there was no indication the orthotic company was called to re-assess the fitting of the [REDACTED] 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 nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility was not routinely monitoring and responding to weights that showed significant weight loss without benefit of re-weigh, nor did the facility ensure scales were accurate and residents with significant weight changes were flagged for immediate nursing and dietician review. The facility also failed to monitor, evaluate, develop and/or implement interventions to prevent weight loss for 6 of 8 residents reviewed for weight loss (#33, 62, 352, 370, 249, 212), in a sample of 57. Findings include: 1. Resident # 33 had diagnoses that included [REDACTED] and [REDACTED]. Per record review, the resident was able to eat independently and was at risk for weight loss. The resident's weight was to be monitored weekly.	F 314 F 325	F-314 4) How the nursing home plans to monitor its performance to make sure that solutions are sustained: • Nurse managers or designee will perform random audits of resident records to ensure appropriate skin assessments are being performed and interventions are in place to address risk factors for development of pressure ulcers. • Audit results will be reviewed by QA Committee and actions plans developed based on trends identified 5) Dates when corrective actions will be completed: October 25, 2013 6) The title of the person responsible to ensure correction: [REDACTED], Administrator	

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F 325	<p>Continued From page 31</p> <p>On 8/14/13 the resident's weight was documented at [REDACTED] pounds. On 8/24/13 the resident's weight was [REDACTED] pounds demonstrating a loss of [REDACTED] pounds ([REDACTED] of her body weight in 10 days). Although this represented a severe unplanned weight loss for the resident, the facility did not identify the issue, evaluate the potential cause of the weight loss, or put interventions in place to prevent further weight loss.</p> <p>The resident was not weighed again until 9/7/13 (14 days later). At that time her weight had dropped to [REDACTED] pounds for a total loss of [REDACTED] pounds ([REDACTED] of her body weight in 24 days). Again, there was no documentation to indicate the facility identified, evaluated, or intervened to correct the resident's severe unplanned weight loss.</p> <p>During an interview on 9/10/13 at 9:45 a.m., Staff N (Registered Dietician), expressed surprise when advised of the resident's weight loss and stated, "Someone should have noticed it." Staff N further stated she was not aware of the weight loss and suggested the resident be re-weighed because some of the weights could be inaccurate.</p> <p>The resident was re-weighed twice on 9/11/13. One weight was documented at [REDACTED] pounds and the other at [REDACTED] pounds. It was unclear which of the weights was accurate.</p> <p>When interviewed on 9/12/13 at 8:20 a.m., the Administrator stated he was not confident that weights were accurate in the building because there were 7 different scales in use and no consistent staff responsible for weights or how residents were weighed.</p> <p>Although a severe unplanned weight loss was documented in the resident record, the facility failed to monitor the resident's weight as planned, failed to identify and evaluate the potential weight</p>	F 325	<p>1) How the nursing home will correct the deficiency as it relates to the resident:</p> <ul style="list-style-type: none"> • Residents # 249 and #370 discharged • Residents #33, 62, 352, and 212 reweighed for accurate baseline. Nutritional status and needs reassessed. Care plans reviewed and updated with recommendations and interventions to maintain nutritional status and to prevent weight loss <p>2) How the nursing home will act to protect residents in similar situations:</p> <ul style="list-style-type: none"> • Facility weight machines audited and recalibrated • All residents will be reweighed and nutritional treatment and care plans will be reviewed and updated if necessary 		

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F 325	Continued From page 32 loss, failed to analyze the accuracy of the weights if questionable, and failed to put interventions in place to prevent further weight loss. 2. Resident #62 had diagnoses that included [REDACTED] and [REDACTED]. Per record review, on [REDACTED]/13 the resident was admitted to the facility with a baseline weight of [REDACTED] pounds. Per facility policy, the resident was to be weighed weekly and monitored for weight changes. On 6/1/13 the resident's weight was recorded as [REDACTED] pounds (demonstrating a loss of [REDACTED] pounds since admission). The resident was not weighed again for two weeks (6/15/13), at which time his weight was [REDACTED] pounds for a total loss of [REDACTED] pounds ([REDACTED]% of his body weight), in 25 days. Although the documentation indicated the resident had experienced severe unplanned weight loss, the facility did not identify the loss, evaluate the potential causes, or put interventions in place to prevent further loss until 7/11/13 (27 days later). Nutrition Committee notes dated 7/11/13 questioned the accuracy of the weight loss and requested a current weight as the resident had not been weighed for 27 days. The resident's weight at that time was [REDACTED] pounds reflecting a total loss of [REDACTED] pounds ([REDACTED]% of his body weight). The Nutrition Committee recommended the resident receive [REDACTED] (a nutritional supplement), twice daily and that he be placed on meal monitoring. According to the record, there was no documentation to indicate meal monitoring was initiated during this time period to determine the residents overall intake. A nutrition note dated 7/17/13 indicated the resident was eating, "50-75% of most meals per staff" but there was	F 325	3) Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur: <ul style="list-style-type: none"> • Facilitated meeting to review operational, weight and nutritional policies and process to include development of guidelines and standards addressing; <ul style="list-style-type: none"> ○ Admission and weekly weight requirements ○ Documentation requirements ○ Weight equipment calibration/monitoring ○ Significant/unplanned weight change and re-weigh process ○ Immediate nursing and/or dietician assessment ○ Nutritional committee oversight and monitoring ○ Meal monitoring /tracking • Nursing and dietary staff will receive an in-service on the requirements under F325 to include use of nutritional supplements and updated operations, weight management and nutritional policies, processes and guidelines 		

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F 325	Continued From page 33 no documentation to support this in the record. On 8/19/13 a Quarterly Nutrition Review note documented there was no current weight in the record (last weight was 33 days ago), but that the resident's intake was "considered good." Again, no documentation regarding the resident's intake was found anywhere in the record to support this determination. The resident's weight on 8/19/13 was [REDACTED] pounds. During an interview on 9/10/13 at 1:45 p.m., Staff N (Registered Dietician), had no explanation as to why the resident's weight loss was not identified sooner or why his weight was not monitored weekly. When asked how the acceptance of supplements was monitored, the RD stated physician ordered supplements were documented on the MAR (Medication Administration Record), and all other supplements were tracked on the meal monitors. Per record review, although there was a physician's order for the supplement on 9/6/13, there was no documentation on the MAR regarding the resident's acceptance of the supplement. Meal monitors were not implemented as recommended by the Nutrition Committee on 7/11/13 so no documentation related to the resident's acceptance of the supplements or overall intake was found. During observations of meals on 9/9/13 lunch, 9/10/13 lunch, 9/11/13 breakfast & lunch: No [REDACTED] was provided to the resident. When interviewed on 9/11/13 at 2:30 p.m. the resident stated he did not get [REDACTED] or anything like it either with or between meals. The surveyor reviewed the resident's record on 9/11/13. At that time the resident's last documented weight was on 8/19/13 (23 days earlier). When the surveyor asked for a more recent weight, the facility weighed the resident.	F 325	4) How the nursing home plans to monitor its performance to make sure that solutions are sustained: <ul style="list-style-type: none">• Nursing managers and dieticians will audit and monitor weight documentation (care tracker & meal monitoring) on a quarterly or as needed basis and implement interventions when required• Nutritional committee will monitor resident outcomes and develop system for follow-up on recommendations• Facility operations will establish and perform a documented weight equipment calibration process to be performed at least quarterly• Managers will periodically monitor staff for compliance with operations, weight and nutritional policies 5) Dates when corrective actions will be completed: October 25, 2013 6) The title of the person responsible to ensure correction: [REDACTED], Administrator		

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F 325	<p>Continued From page 34</p> <p>The resident's weight on 9/11/13 was [REDACTED] pounds.</p> <p>The facility failed to monitor the resident's weight consistently in order to identify weight loss, failed to identify severe unplanned weight loss when it occurred, failed to evaluate unplanned weight loss, failed to take prompt action to prevent further weight loss, failed to monitor and evaluate the effectiveness of planned interventions, failed to implement Nutrition Committee recommendations for meal monitoring, and failed to provide the resident with supplements as planned and/or ordered by the physician.</p> <p>3. Resident # 352 had diagnoses that included [REDACTED], [REDACTED], and [REDACTED]. Per record review, the resident was alert and oriented and able to eat and drink without assistance. The resident was provided with a sack lunch three times per week when she was out of the facility for medical treatment.</p> <p>The resident was admitted to the facility on [REDACTED]/13 with a documented weight of [REDACTED] pounds. A nutritional assessment dated 8/22/13 determined the resident was at risk for weight loss due to poor intake and medical conditions. The physician wrote orders the same day for an appetite stimulant to be administered daily and [REDACTED] (a nutritional supplement) to be provided with all meals. The resident was to be weighed daily and meal monitoring was to be documented for a two week period.</p> <p>According to the record, weights were not obtained on 8/22/13 or 8/23/13. On 8/24/13 the resident's weight was [REDACTED] pounds demonstrating a loss of [REDACTED] pounds ([REDACTED]% of her body weight). There was no evaluation of the resident's severe unplanned weight loss in the</p>	F 325		

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F 325	<p>Continued From page 35 record.</p> <p>On 8/25/13 the resident weighed [REDACTED] pounds for a total loss of [REDACTED] pounds. No weight was documented for 8/26/13, but on 8/27/13 the resident's weight was down to [REDACTED] pounds. Staff N signed off on the nutritional assessment on 8/27/13, but failed to take note of or address the [REDACTED] pound weight loss documented in the record. The following day the resident was down to [REDACTED] pounds for a total loss of [REDACTED] pounds ([REDACTED]% of her body weight in 7 days). Again, there was no evaluation of the resident's severe unplanned weight loss in the record.</p> <p>Between 8/29/13 and 9/6/13 the resident's weight fluctuated between [REDACTED] and [REDACTED] pounds. The resident was not weighed 4 out of 15 days. Meal monitors for the resident were not completed and only recorded the intake of 4 out of 38 meals. The resident ate 25% or less of the 4 documented meals.</p> <p>On 9/6/13 at 12:30 a.m. the resident returned to the facility after a scheduled medical treatment. The resident's uneaten sack lunch was spread out on her overbed table. The resident stated she was not hungry and did not eat the sack lunch provided by the facility for her [REDACTED]. The resident was not provided with a replacement meal. Similar observations were made on 9/11/13.</p> <p>During an interview on 9/7/13 at 1:45 p.m., the resident stated she wasn't drinking the [REDACTED] because, "It doesn't taste good to me." The resident further stated she had lost a lot of weight since she had been sick, but she didn't know how much. Two full bottles of [REDACTED] were observed on her bedside table at the time of the interview. On 9/9/13 there were seven bottles of [REDACTED] on the night stand. All of the bottles were full and unopened.</p>	F 325	

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F 325	<p>Continued From page 36</p> <p>When interviewed on 9/10/13 1:45 p.m., Staff N stated she was not aware of the resident's weight loss, but stated the initial weight of [REDACTED] pounds was probably inaccurate. When asked how the acceptance of supplements was monitored, Staff N stated physician ordered supplements were documented on the MAR (Medication Administration Record).</p> <p>Per record review, there was no documentation of supplement acceptance on the resident's MAR. Staff N further stated meal monitoring should be done for a two week period as part of the nutritional assessment and she could not explain why the resident was only monitored for 4 meals. Staff N was not aware the resident ate 25% or less of the meals that were documented, or that the resident was not drinking the [REDACTED] provided.</p> <p>Although the resident was assessed as being at risk for weight loss and had interventions planned to prevent weight loss, the facility failed to determine an accurate baseline weight at the time of admission, failed to complete a nutritional assessment based on an accurate weight, failed to analyze a significant weight discrepancy, and failed to identify potential severe unplanned weight loss.</p> <p>In addition, the facility failed to monitor the resident's weight on a daily basis as ordered by the physician, failed to consistently monitor the resident's meal intake and acceptance of supplements, and failed to evaluate the effectiveness of the interventions and/or develop alternate interventions as needed.</p> <p>4. Resident #370 was admitted on [REDACTED]/13 with diagnoses of [REDACTED] with recent [REDACTED], [REDACTED], and a [REDACTED]. He had an [REDACTED], and was on antibiotics for the [REDACTED].</p>	F 325		

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F 325	<p>Continued From page 37</p> <p>The admission assessment of 9/3/13 documented his weight at [REDACTED] pounds (lbs.). The resident had suffered from nausea, vomiting, and frequent diarrhea primarily from the [REDACTED], and had required [REDACTED] nutrition in the hospital. According to the the Interdisciplinary Progress Notes (IPN) from the facility, the resident continued to suffer from nausea and diarrhea, and was consuming very little food/fluids. Because of these factors, he was at high risk for further weight loss and dehydration. A physician order on [REDACTED]/13 (the day of admit) requested a Registered Dietician (Staff #N) consult and nutritional supplement drinks to be given three times a day.</p> <p>The initial nutrition assessment of [REDACTED]/13 documented the resident's weight was [REDACTED] lbs. - this weight was collected from the hospital records of [REDACTED]/13, and was [REDACTED] pounds higher than his actual admission weight. Per interview with Staff #N on 9/10/13 at 1:20 p.m., preliminary data (such as the initial weight) was entered by the dietary tech (Staff #M) when residents were new to the facility. Staff #N would then review the data, add additional comments if necessary and put interventions in place. The actual Registered Dietician evaluation for resident #370 was done on [REDACTED]/13 (7 days after admission). The weight disparity of [REDACTED] lbs. was not identified or assessed. There was no information to indicate whether the resident was consuming the nutritional supplement which had been ordered on the day of admission. Staff #N also requested staff begin monitoring the resident's meal intake. The resident's care plan for nutrition was reviewed on 9/10 - no interventions were identified to prevent further weight loss.</p> <p>The resident sent was sent to the hospital with [REDACTED] (as a result of multiple factors</p>	F 325		

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F 325	<p>Continued From page 38</p> <p>including dehydration) on [REDACTED]/13. His weight at admission to the hospital was [REDACTED] lbs. - a weight loss of [REDACTED] pounds in one week (using the facility admission weight of [REDACTED] lbs.).</p> <p>The facility did not ensure that the nutritional assessment was done with the resident's actual weight, did not identify or assess the large disparity in weight, initiate a care plan, or determine if the initial intervention (i.e. a nutritional supplement) was given as ordered and consumed.</p> <p>5. Resident #249 had diagnoses of [REDACTED] with [REDACTED] repair and [REDACTED]. He was admitted to the facility on [REDACTED]/13, with a weight of [REDACTED] lbs.</p> <p>The initial nutritional assessment of 4/10/13 indicated the resident's stated weight was [REDACTED] lbs. - 25 pounds less than his actual weight. The initial Minimum Data Set of 4/15/13 documented his weight as [REDACTED] lbs. - an 18 pound difference than the weight on the nutritional assessment, and 7 lbs. less than his actual admission weight.</p> <p>In addition, on 4/12/13, the resident's weight (from the facility record) was [REDACTED] - a possible gain of [REDACTED] lbs. in 4 days (or [REDACTED] lbs. if the weight on the initial nutritional assessment was used). On the next day (4/13/13), the resident's weight was [REDACTED] - a possible loss of [REDACTED] lbs. in 4 days (or a gain of [REDACTED] lbs. using the weight from the nutritional assessment).</p> <p>On the 9/10/13 at 1:20 p.m., the Registered Dietician was interviewed. She acknowledged the disparity in weights.</p> <p>The facility failed to identify a large disparity in weights, determine the cause, or put a plan in place to ensure weight accuracy. The initial nutritional assessment was based on a weight that was 25 pounds less than the resident's actual</p>	F 325		

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F 325	<p>Continued From page 39</p> <p>weight.</p> <p>6. Resident #212 was admitted [REDACTED]/13 with a previous [REDACTED], inability to [REDACTED] lower [REDACTED], and required assistance with all activities of daily living. In addition, the resident was admitted with [REDACTED] and was continuing to receive treatment.</p> <p>Review of the hospital dietician consult dated [REDACTED]/13 (prior to admit to the facility) revealed the resident's weight was [REDACTED] pounds (lb), had moderate-severe protein calorie malnutrition related to poor nutritional intake prior to admit, and required increased nutrient needs for wound healing.</p> <p>A nutrition assessment note dated 6/19/13 revealed Staff #M, the dietary technician, based the resident's initial nutrition assessment on a weight of [REDACTED] lb. Staff #M identified there was no documented weight on admit.</p> <p>Review of the facility comprehensive assessment dated 6/23/13 also revealed the resident's weight was [REDACTED] lb.</p> <p>The resident's care plan for weight loss did not identify any interventions for weight monitoring.</p> <p>The facility did not weigh the resident until [REDACTED]/13, 25 days after admission. The resident's weight was [REDACTED] lb, which represented either a weight loss of [REDACTED] lb or [REDACTED] lb. There was no re-evaluation of the weight loss until 8/29/13.</p> <p>The resident's weight on 8/30/13 was [REDACTED] lb and [REDACTED] lb on 9/2/13 ([REDACTED] lb weight increase). The facility failed to evaluate the weight change and take necessary measures, including re-weighing the resident to verify the accurate weight.</p> <p>On 9/5/13, at the request of the surveyor, the resident was re-weighed and the weight was [REDACTED] lb.</p>	F 325		

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F 325	Continued From page 40 In an interview on 9/6/13 at 11:00 a.m. and 9/9/13 at 2:30 p.m., Staff #M stated residents should be weighed on admit and weekly after that. She confirmed there was no resident admit weight when she completed the nutritional assessment on 6/19/13. She stated the identified weight of [REDACTED] lb was the hospital weight on 6/15/13. She stated she sent a request to the resident care manager to weigh the resident. Staff #M stated after she completed the nutritional assessment she reviewed the hospital weights and determined the hospital weight of [REDACTED] lb was probably the accurate weight. According to Staff #M, she did not document a re-evaluation using the lower weight because the resident was receiving assistance to eat and her intake was being monitored. In an interview on 9/10/13 at 9:10 a.m., the surveyor asked the nurse who completed the comprehensive assessment dated 6/23/13 how she obtained the weight of [REDACTED] lb. She stated the resident's baseline weight from the hospital was [REDACTED] lb. She asked a staff member to weigh the resident and obtained a weight of [REDACTED] lb. She stated resident weights might be different depending on whether the bath aid weighed the resident at the time of the shower or staff weighed the resident at a different time. The facility failed to determine the cause of a large disparity in weights, or put a plan in place to ensure weight accuracy.	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	F 329			

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F 329	<p>Continued From page 41</p> <p>without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure 1 of 5 reviewed for unnecessary medications (#357), in a sample of 56 was free of unnecessary medications related to use of an as needed anti-psychotic medication (██████████) without adequate indications for use and/or monitoring.</p> <p>Findings include:</p> <p>Resident #357 was admitted to the facility ██████/13 for ██████ and ██████ following a ██████. The resident had diagnoses including ██████, ██████,</p>	F 329	<p>1) How the nursing home will correct the deficiency as it relates to the resident:</p> <ul style="list-style-type: none"> Resident #357 discharged <p>2) How the nursing home will act to protect residents in similar situations:</p> <ul style="list-style-type: none"> Records and Care Plans for residents on Antipsychotic drugs will be reviewed and updated, if applicable, to ensure documentation for indications of use, appropriate diagnosis, behavioral monitoring, non-pharm interventions, informed consent, and Gradual Dose Reduction. <p>3) Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p> <ul style="list-style-type: none"> Psychotropic Medication policy and procedures reviewed and updated Nursing staff will be in-serviced on the requirements under F329 to include all requirements outlined in updated policy and procedures 	

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F 329	<p>Continued From page 42</p> <p>██████████, and a new ██████████ issue.</p> <p>According to the 9/1/13 History and Physical, the resident was very confused and his conversation did not make sense. He had generalized weakness, tried to get up frequently, and was a high fall risk.</p> <p>There was a 9/1/13 practitioner's order for ██████████ twice a day as needed, there was no diagnosis identified.</p> <p>The resident experienced two non injury falls on 9/2/13.</p> <p>The facility did not initiate behavior monitoring sheets or non medication interventions to address the behaviors until 9/4/13 after the resident had received at least three doses of the anti-psychotic medication.</p> <p>The facility's progress notes indicated the resident had behavioral issues including; wandering, restless, agitated, and poor impulse control. The resident's received six doses of the ██████████ medication from 9/2-8/13 to treat the behavior symptoms. The medication was not helpful in treating the symptoms on at least three occasions.</p> <p>The practitioner saw the resident on 9/4/13 and identified the resident's thyroid lab levels were high documented it may have contributed the the resident's agitation and mental changes, but not the only cause.</p> <p>Staff #O was interviewed on 9/10/13 regarding the medication. She was unable to provide any information related to the facility's evaluation of the resident's behaviors prior to the initiation of the anti-psychotic medication.</p> <p>The facility did not perform a baseline evaluation to monitor for potential adverse side effects prior to the initiation of the medications. There was no justification for the implementation of the as needed anti-psychotic medication and</p>	F 329	<p>4) How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <ul style="list-style-type: none"> • Nurse Managers or designee will perform random audits of residents who triggered for use of Antipsychotic medications to ensure appropriate documentation is in place to include; clinical indications, diagnosis, non-pharm interventions, informed consents, and Gradual Dose Reduction • Pharmacy Report for Gradual Dose Reduction will be reviewed and discussed through the QA Committee <p>5) Dates when corrective actions will be completed:</p> <p>October 25, 2013</p> <p>6) The title of the person responsible to ensure correction:</p> <p>██████████, Administrator</p>	

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F 329	Continued From page 43 non medication interventions were not implemented for two days after the medication was started.	F 329	1) How the nursing home will correct the deficiency as it relates to the resident:	
F 333 SS=G	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure 3 of 57 sample residents were free of significant medication errors (#208,324,370). Residents #208 and 370 experienced harm. Findings include: 1. Resident #370 was admitted to the facility on [redacted]/13 for [redacted] and [redacted] care. He had diagnoses including [redacted] issues, [redacted] issues, [redacted] and [redacted]. The resident was seen by a practitioner on [redacted]/13 after he was admitted to the facility. The assessment indicated the resident was tired, ached all over, had chronic nausea and found it difficult to eat/no appetite. The resident was interviewable at the time and reported to the practitioner he had pain due to his [redacted]. The resident said the medication [redacted] worked for him in the past. The practitioner ordered [redacted] mg every 6 hours as needed. The [redacted] medication was added to the September 2013 Medication Administration Record (MAR) by a licensed nurse. The	F 333	<ul style="list-style-type: none"> Resident #370 incident report reviewed and updated to include summary of incident, conclusion, and corrective action plan Residents #208 and 324 – See F Tag 225 2) How the nursing home will act to protect residents in similar situations: <ul style="list-style-type: none"> See F Tag 225 3) Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur: <ul style="list-style-type: none"> See F Tag 225 Clinical staff will receive focus training on medication administration and prevention of medication errors Facilitated training session with nurse managers on analysis of medication errors focusing on the use of the investigation tools to help identify the root cause 	

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F 333	<p>Continued From page 44</p> <p>medication was written as ● mg routinely every 6 hours, rather than as needed.</p> <p>The following information was reviewed on The Internet Drug Index (RxList). ● is a nonsteroidal anti-inflammatory medication indicated for short-term use (up to five days). It is not indicated for minor or chronic painful conditions. The maximum dose in adults is 40 mg, increasing the dose will not provide better efficacy but will increase the risk of developing serious adverse side effects. The side effects of the medication include but are not limited to; renal risk for resident with advanced renal impairment and in residents with volume depletion (dehydration).</p> <p>The facility's progress notes were reviewed from 9/5-10/13, the following information was identified regarding the resident. The resident had a fever, he complained of nausea, had diarrhea, had a poor appetite, had wound drainage, and staff encouraged him to drink fluids. The documentation indicated he was lethargic/sedated at times. The practitioner was notified of his condition, but the ● was not mention.</p> <p>The evening of 9/9/13, the practitioner wrote orders to discontinue the ● and lower the dosage of routine ●</p> <p>On ●/13 the resident was transferred to the hospital emergency room at 1:15 p.m. after the physician assessed him. The resident had an elevated ● level of ● (normal range 0.7-1.3) and was lethargic. The physician documented the resident's laboratory values showed acute ● failure, with no previous history of ● problems. The physician identified the resident was on ● every 6 hours as needed and as needed ● "which seems to be the obvious culprits</p>	F 333	<p>4) How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <ul style="list-style-type: none"> • See F Tag 225 • Director of Clinical services or designee will review medication error reports to ensure a root cause has been identified and appropriate actions taken to mitigate reoccurrence • Medication errors and trending reports reviewed by QA Committee for on-going process improvement activities <p>5) Dates when corrective actions will be completed:</p> <p>October 25, 2013</p> <p>6) The title of the person responsible to ensure correction:</p> <p>● Administrator</p>	

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F 333	<p>Continued From page 45 (of the acute [redacted] failure)".</p> <p>According to the 9/10/13 History and Physical from the hospital, described the resident as somnolent and unable to give a history. The document identified the [redacted] was meant to be [redacted] mg every 6 hours as needed but was given every 6 hours routinely for five and a half days. The hospital physician, documented the resident had acute [redacted] failure and suspected the cause was the nonsteroidal anti-inflammatory medication use ([redacted] and [redacted]) and dehydration.</p> <p>On 9/11/15 at 3:10 p.m., the [redacted] medication card from the pharmacy listed the medication instructions as needed every 6 hours (not routinely). The card was delivered on 9/3/13 and 23 doses of the medication were administered.</p> <p>A practitioner involved with the resident's care was interviewed on 9/12/13 at 9:30 a.m. She stated the resident was admitted to the facility with dehydration, nausea, and poor intake. It was questionable whether he would need to be sent back to the hospital. The practitioner verified [redacted] was a medication that should not be given more than five days routinely. She commented the medication was not the sole cause of the resident's condition.</p> <p>The resident was admitted to the facility on [redacted]/13 and was to receive [redacted] on an as needed basis. The medication was not transcribed onto the medication log accurately. Therefore, the resident received the medication for over five days at the maximum dose recommended. At least 6 different nurses administered the medication on a regular basis from the medication card which had instructions to give the medication as needed. The resident had acute [redacted] failure and was sent to the</p>	F 333		

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F 333	<p>Continued From page 46</p> <p>hospital. Two different physician's identified the resident's medication regime as contributing factors to the resident's condition.</p> <p>2. Resident #208 had diagnoses of [REDACTED] and [REDACTED] disease. The resident was taking as needed medication for pain, as well as a [REDACTED] (narcotic pain medication applied directly to the [REDACTED] which provides a continuous dose). The physician orders instructed staff to change the [REDACTED] every 72 hours.</p> <p>Per the May 2013 record, the resident's [REDACTED] was replaced on 5/14/13. On the morning of [REDACTED]/13, the resident complained of not feeling well, being anxious and nauseated, had tingling of the extremities, and eventually experienced uncontrolled shaking/jerking. She was sent to the emergency room (ER), and was given a medication for the uncontrolled movements (which according to the record was minimally helpful), pain medication, and medication for anxiety. After the resident received the pain/anxiety medications, she stated she felt well (and her symptoms resolved). During the ER stay, the resident discovered that the [REDACTED] was not on. Diagnoses on the emergency room report included probable [REDACTED] and [REDACTED].</p> <p>The resident experienced probable [REDACTED] symptoms because she was not receiving the medication for an undetermined period of time. (See F-225 related to lack of investigation of the medication error).</p> <p>3. Per record review, Resident #324 was admitted for treatment of [REDACTED] problems. The resident was alert and oriented and was</p>	F 333		

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F 333	Continued From page 47 independent with set-up for most activities of daily living. The resident's August 2013 medication orders included [REDACTED] medications for nausea, itching, and pain. Review of the facility investigation dated 8/21/13 revealed a night shift licensed nurse administered the wrong dose of [REDACTED] nausea medication. The medication order was for [REDACTED] milligrams (mg) every 6 hours as needed. If needed, the medication dosage could be repeated 1 time for a total of [REDACTED] mg. On 8/21/13 at 5:15 a.m., the licensed nurse gave [REDACTED] mg at one time (double the maximum dosage ordered). Per record review, the resident's vital signs were stable and the resident requested [REDACTED] pain medication 45 minutes later. In an interview on 9/9/13 at 3:30 p.m., the resident stated she was sleeping but staff informed her family member of the medication error when it occurred. In an interview on 9/9/13 at 3:45 p.m., Staff #K stated the medication was dispensed as [REDACTED] mg in a [REDACTED] milliliter (ml) [REDACTED] ([REDACTED] mg = [REDACTED] ml). The licensed nurse administered the entire ml rather than [REDACTED] ml and recognized and reported the error immediately.	F 333			
F 353 SS=F	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	F 353			

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F 353	<p>Continued From page 48</p> <p>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:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure sufficient staff was available to provide necessary care for residents in a timely manner related to bathing services, dining, and responses to calls for assistance with basic activities of daily living. Affected were 9 of 15 residents on the Main and Garden level (#3, 342, 369, and 7 residents who wished to remain anonymous) observed and/or interviewed during Stage I; and 9 of 28 residents (#1, 6, 24, 69, 81, 131, 134, 163, 170) who dined in the Garden level large dining room. Residents were placed at risk for a diminished quality of life and unmet care needs. Findings include:</p> <p>RESPONSE TO CALL LIGHTS</p> <p>1. Per record review, Resident #369 was admitted [REDACTED] 13 with no history of falls prior to admission and one fall without injury since admission.</p>	F 353	<p>1) How the nursing home will correct the deficiency as it relates to the resident:</p> <p>(See F Tag 241 & 242 for more details)</p> <p>RESPONSE TO CALL LIGHTS</p> <ul style="list-style-type: none"> Resident #369 discharged <p>DINING SERVICES GARDEN LEVEL</p> <ul style="list-style-type: none"> Residents #1, 6, 24, 69, 81, 131, 134, 163, and 170 assessed for ADL's, and dining assistance <p>BATHING SERVICES</p> <ul style="list-style-type: none"> Resident #342 discharged Resident #3 assessed for ADL's and bathing needs/preferences <p>2) How the nursing home will act to protect residents in similar situations:</p> <ul style="list-style-type: none"> See F Tag 241 and 242 	

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F 353	<p>Continued From page 49</p> <p>On 9/10/13 at 4:30 p.m., Resident #369 called out for help from her room on the main level. There was no staff in sight. The surveyor found the resident sitting up in a low bed with her feet on the floor, clutching her call light and trying to stand up. The resident said she wanted to get up and did not activate the call light. With the residents' permission, the surveyor activated the call light.</p> <p>Staff did not respond to the resident's call light until 4:45 p.m., 15 minutes later, when activity staff distributing activity schedules entered the resident's room. The resident said "help" when she saw the staff member and then could not remember what she wanted.</p> <p>During interviews on 9/4/13 and 9/5/13, 7 residents who wished to remain anonymous were asked if the facility had enough staff available to make sure they received the care and assistance they needed without having to wait a long time. Five residents on the main floor and 2 residents on the Garden Level reported waiting from 20 to 45 minutes on all shifts.</p> <p>DINING SERVICES GARDEN LEVEL</p> <p>2. Review of the July 2013 Resident Council meeting revealed there were concerns about food trays not being passed out in a timely manner. Residents were advised that non-clinical staff were helping to serve meals.</p> <p>During observation of lunch in the Garden Level large dining room on 9/6/13, non-clinical staff did not help serve meals. Eight residents (#1, 6, 24, 69, 131, 134, 163, 170) waited 30-55 minutes to eat. Resident # 81 was brought to the dining room 10 minutes after meal service ended.</p> <p>Nursing assistants assigned to assist the residents were interviewed after the meal. They</p>	F 3533	<p>3) Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p> <ul style="list-style-type: none"> • See F Tag 241 and 242 • Call light policy will be reviewed and revised if necessary • All staff will be in-served on facility call light policy to ensure compliance with call light response guidelines • Staff schedules and process will be reviewed to ensure adequate coverage to assist at meal times <p>4) How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <ul style="list-style-type: none"> • See F Tag 241 and 242 • Nurse managers or designee will monitor staff for timely responses to call lights and assistance with meals <p>5) Dates when corrective actions will be completed:</p> <p>October 25, 2013</p> <p>6) The title of the person responsible to ensure correction:</p>	
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Administrator

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F 353	<p>Continued From page 50</p> <p>reported being late to the meal because they were assisting other assigned residents with personal care. See F241 for additional details. BATHING SERVICES</p> <p>3. Per review of bathing records from 7/1/13 through 9/6/13, there were 13 residents that went more than 7 days without a bath or a shower on at least 1 occasion and 1 resident went 12 days without a bath/shower during this time frame.</p> <p>Review of the monthly Resident Council minutes identified the Council expressed concerns in June and July of 2013 regarding lack of bathing, when the bath aide either called in or was not available.</p> <p>On 9/4/13 at 9:10 a.m., Resident #342 stated she was supposed to have showers twice a week and was not getting 2 showers because the shower aide was off work for 2 months.</p> <p>On 9/4/13 at 10:15 a.m., Resident #3 stated he usually received 1 shower per week, but missed a lot of showers due to short staffing and call ins. He commented that baths were the first thing to be cut if the facility was short staffed.</p> <p>In an interview on 9/9/13 at 12:00 p.m., Staff #S stated the staffing for nursing assistants was terrible, 3 out of the 4 days the nursing assistants were short and the weekends were very hard. Staff #S also stated there were two regular bath aides but one of them had been on leave from July to September. He said it's hard because they had to decide "should we pull from the floor to do baths, or from the bath to work on the floor."</p> <p>On 9/9/13 at 2:30 p.m., Staff #T stated the days there was no bath aide available it was hard because the evening staff had to try to get them done.</p> <p>In an interview on 9/10/13 at 10:30 a.m. Staff</p>	F 353			

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F 353	Continued From page 51 #U said it was a struggle to get baths done when people call off their scheduled shift in which the evening shift had to try and catch up on resident's baths. In an interview on 9/10/13 at 10:30 a.m., Staff #U said it was a struggle to get baths done when people call off their scheduled shift in which the evening shift had to try and catch up on residents' baths. In an interview on 9/12/13 at 1:05 p.m., Staff #L (DNS) said there were several factors that determined staffing which included acuity and number of admissions. Staff #L said there were times when more staff were added to the schedules for different reasons and pulling the bath aide was the last resort. Although Staff #L stated pulling the bath aide was the last resort, record review and interviews confirmed the bath aide was being pulled from bath duties and it was affecting the resident's quality of care related to bathing.	F 353		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP 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. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide food that was served at a consistency to maintain food quality and palatability to ensure resident satisfaction. Potentially affected were residents in	F 364		

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F 364	<p>Continued From page 52</p> <p>all dining rooms served beef short ribs for lunch on 9/3/13. Findings include:</p> <p>1. During observation of dining services on 9/3/13 at lunch in the Garden Level large dining room the following was observed: At 11:47 a.m., a staff member came in with menus and commented to the dietary aide that residents in the Garden Level small dining room said the ribs were too tough to eat and "going over like a lead balloon." Observation of food served in the large dining room revealed the main entree was beef short ribs served with bone attached. Residents were having difficulty cutting the meat. Several residents attempted to pick up the bone and chew the meat from the bone. A staff member obtained a steak knife from the kitchen to cut the meat off the bone and remove the gristle and fat. After their meat was cut, 2 residents ate bites of meat and placed chewed meat back on the plate. These residents did not accept alternate food.</p> <p>2. Resident #133 was having lunch in the main level dining room on 9/3/13 at 12:10 p.m. The main entree included short ribs/spare ribs. She was having difficulty cutting the meat off the bone to eat it. The resident had specialized utensils (to make cutting and eating food easier) including a curved handle knife. After attempting several times to cut the meat without success, the resident said "this is stupid - how are we supposed to eat these?" At that point she stopped trying to eat them, ate the rest of the food that was on her plate, and her dessert. At approximately 12:20 p.m. the resident started tearing pieces of meat off with her fingers</p>	F 364	<p>1) How the nursing home will correct the deficiency as it relates to the resident:</p> <ul style="list-style-type: none"> Resident #133 discharged Resident # 87 and 52 interviewed by dietary manager regarding dissatisfaction with beef short ribs offered on 9/3/13 and discussed ways to improve their dining experience <p>2) How the nursing home will act to protect residents in similar situations:</p> <ul style="list-style-type: none"> Dietary manager and Food Service Committee to review future menu items to ensure they meet residents needs regarding; consistency, methods available, flavor, appearance, palatability, attractiveness, and proper temps. 		

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F 364	<p>Continued From page 53</p> <p>(after making another unsuccessful attempt using the utensils). She put a large piece of meat in her mouth, tried to chew it, took it out, threw it on her plate, and pushed the plate away. She finished her protein drink (she made a loud sound trying to suck more fluid out of the empty container).</p> <p>At no time during the meal did facility staff notice the difficulty she was having, or offer to assist her in cutting the meat. At approximately 12:35 p.m. Staff O talked to Resident #133's tablemates about the food, but did not offer assistance to the resident.</p> <p>When interviewed about the meal, the resident gestured at the meat and said it was "tough." One of the other residents at the table was interviewed, and stated the meat was "greasy" - that resident had eaten only a few bites.</p> <p>The surveyor had additional random observations in the main level dining room at lunch on 9/3/13: a female resident had difficulty cutting the meat off the bone - there was visible fatty material when the resident attempted to separate the meat from the bone. A staff person offered to cut the meat for her after approximately 10 minutes. Initially she said no, but later consented. She took a couple of bites of meat and left the rest. Multiple other residents were struggling to cut and eat meat in the main level dining room during lunch on 9/3/13. Staff were inconsistent in offering assistance or an alternate food item.</p> <p>3. On 9/3/13 during the lunch meal, in the Garden level independent dining room, the following was observed: At 11:55 a.m., Resident #87 and Resident #52 sat at a table together while they ate their their</p>	F 364	<p>3) Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p> <ul style="list-style-type: none"> • See F Tag 241 • Dietary and nursing staff will be in serviced on identifying resident with difficulty eating or concerns on palpability of meal and offer alternatives <p>4) How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <ul style="list-style-type: none"> • See F Tag 241 <p>5) Dates when corrective actions will be completed: October 25, 2013</p> <p>6) The title of the person responsible to ensure correction: ██████████, Administrator</p>	

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F 364	<p>Continued From page 54</p> <p>lunch which included beef short ribs. Resident #87 grabbed a large chunk of meat with her hands that hadn't been cut up and tried to bite into it. She was not able to get any into her mouth because it was so tough and grisly. The resident continued to pull on the meat with her teeth and pull away with her hand until she got some in her mouth. The resident then said "tell them to send down some meat that's not so tough that we can chew on."</p> <p>During this time, Resident #52 said "this meat is really tough." Resident #52 had a very difficult time chewing the meat and her food was not cut up for her.</p> <p>The residents were observed from 11:55 a.m. until 12:15 p.m., trying to eat the short ribs and complaining of how tough they were. Staff #B was observed in the dining room during this time and did not offer the two residents anything else to eat though they were complaining and having a difficult time eating.</p> <p>In an interview on 9/3/13 at 12:22 p.m., Staff #B was asked what he would do if a resident was having a hard time chewing the food, he said he would help the resident or offer a food alternate to the resident. Staff #B confirmed he did not offer an alternate or offer assistance during the above observations of Resident #87 and Resident #52. Staff #B then left the dining room without assisting the residents or offering them an alternate.</p> <p>At 12:25 p.m., Resident #87 moved away from the table and went out into the hallway and asked Staff #Bb (who was working at the nurse's station) if there was anything else she could eat because she was still hungry. Staff #Bb said she would get the resident something else to eat.</p> <p>At 12:28 p.m., Resident #52 asked this surveyor if she could have something different</p>	F 364		

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F 364	Continued From page 55 because she couldn't eat the meat and she was still hungry, no direct care staff offered her anything prior to this statement. At this time Staff #Bb came into the dining room and offered the resident something more to eat, and the resident accepted. 4. At 12:45 p.m., the surveyor conducted a test tray of the beef short ribs with Staff #A, the kitchen supervisor, and Staff #I, a dietitian. Staff #A used a sharp knife to cut the meat off the bone, cut away the visible fat and gristle, then cut the meat crosswise against the grain. When cut in that manner, the meat had good flavor and was easo;u chewed. Staff #A confirmed the meat served to residents was not cut up to be easily chewed and residents did not have access to sharp knives to cut the meat as served.	F 364		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the	F 431		

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F 431	<p>Continued From page 56</p> <p>facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure 5 of 7 refrigerators were at an acceptable temperature to store medications for residents.</p> <p>Findings include:</p> <p>Medication Storage was reviewed on 9/11/13 at 1:15 p.m. with Staff #O. The following concerns were identified at that time:</p> <p>1. The 3rd floor medication refrigerator had several different medications that required refrigeration. The temperature on the thermometer on the inside was 45 degrees Fahrenheit. The refrigerator had a temperature alarm with the temperature range set from 42-52 degrees. Medications should be stored between 35-45 degrees Fahrenheit. If the temperature was outside that range.</p>	F 431	<p>1) How the nursing home will correct the deficiency as it relates to the resident:</p> <ul style="list-style-type: none"> No specific resident identified <p>2) How the nursing home will act to protect residents in similar situations:</p> <ul style="list-style-type: none"> Audit conducted of medication refrigerators located on 3rd floor, East Main, West, Middle, and East Garden Level and contents discarded if compromised by incorrect storage temperature All seven medication refrigerators adjusted and tested to correct temperature 		

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F 431	<p>Continued From page 57</p> <p>The alarm was suppose to sound to ensure medications were stored at the appropriate temperature in the refrigerator.</p> <p>2. The east main floor medication refrigerator had an internal temperature of 32 degrees Fahrenheit and there was ice droplets on the inside of the refrigerator. The alarm temperature was set from "37 to hh" and was not sounding at the time. The staff member was not sure what the "hh" stood for. The refrigerator did contain resident medications including liquid seizure medication, breathing medication, liquid anti-anxiety medication, and injectable insulin. Other house supply medications were also stored in the refrigerator.</p> <p>3. The west garden level medication refrigerator's internal temperature was 2 degrees Celsius and the temperature alarm was set at 10 to 30 degrees Celsius. The conversion to Fahrenheit would be the internal temp was 35.6 and the alarm range was 50 to 86 degrees. The alarm was not sounding. There was a build up of ice on walls and in corners of the refrigerator, approximately 3/4 inches thick. The refrigerator contained liquid medications for residents receiving hospice services, eye drops, breathing treatments, insulin, and suppositories.</p> <p>4. The middle garden level medication refrigerator's internal temperature was 40 degrees Fahrenheit and the alarm was set 35-45 degrees. The alarm was sounding intermittently at the time of the observation.</p> <p>5. The east garden level medication refrigerator had an internal temperature of 34 degrees and the alarm was set 32 to 37 degrees Fahrenheit.</p>	F 431	<p>3) Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p> <ul style="list-style-type: none"> Medication Refrigerator Alarms policy reviewed and updated to include daily temperature logs for on-going monitoring of temperatures Maintenance supervisor and applicable nursing staff will be in-serviced on requirements of F431 to include updated Medication Refrigerator Alarms policy and incorporation of temperature logs <p>4) How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <ul style="list-style-type: none"> Nursing managers or designee will establish a process for monitoring and recording medication refrigerators using daily temperature log Maintenance supervisor or designee will establish a process and perform on-going auditing and monitoring of medication refrigerator temperatures logs to ensure compliance 		

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F 431	<p>Continued From page 58</p> <p>There was frozen condensation on the the walls. The refrigerator contained resident medications including: eye drops, liquid medications, and insulin.</p> <p>6. Staff #O was interviewed on 9/11/13 regarding the medication refrigerators. She stated the temperatures should be between 35-45 degrees Fahrenheit.</p> <p>The Medication Refrigerator alarms policy indicated the alarms should be set between 35-45 degrees Fahrenheit.</p> <p>Four of the seven medication refrigerators had temperature alarms that were not set at the appropriate temperature range for medication storage.</p> <p>Three of the seven refrigerators had visible ice inside the refrigerator and two of those had internal temperatures less than 35 degrees. The medications stored in the refrigerators was appropriate consistency.</p> <p>One of the seven refrigerator alarm sounded when the temperature was appropriate.</p> <p>On 9/12/13 at 11:40 a.m. Staff #W (maintenance personnel) was interviewed. He stated maintenance checked the refrigerators monthly for electrical issues and check/set the temperature alarms. He stated the temperature should be set 35 to 45 degrees Fahrenheit. When asked about the discrepancies of the alarm settings, he stated when alarm boxes got bumped they reset the temperatures.</p> <p>The facility did not have a system to ensure refrigerated medications were stored at recommended temperatures. The alarm system that was established to monitor the temperatures was not consistent in alarming and was not set accurately.</p>	F 431	<p>5) Dates when corrective actions will be completed: October 25, 2013</p> <p>6) The title of the person responsible to ensure correction: ██████████, Administrator</p>		

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F 496 SS=D	<p>483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING</p> <p>Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.</p> <p>Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual.</p> <p>If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to receive registry verification for 2 of 5 nursing assistants (#X, Y) reviewed. Findings include:</p>	F 496	<p>1) How the nursing home will correct the deficiency as it relates to the resident:</p> <ul style="list-style-type: none"> • New employees #X and Y had OBRA Registry Verification background checks performed <p>2) How the nursing home will act to protect residents in similar situations:</p> <ul style="list-style-type: none"> • Audit conducted on new hires to ensure OBRA Registry Verification background checks conducted <p>3) Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p> <ul style="list-style-type: none"> • VP of Human Resources contacted Talent Acquisition and reviewed on-boarding process to verify requirements for OBRA Registry Verification background checks on all new hires • Talent Acquisition updated all job postings templates to include OBRA Registry Verification which triggers on-boarding checks • Talent Acquisition conducted audit of all current job posting and identified list of employees needing OBRA Registry Verification • Talent Acquisition notified recruiters and provided training on OBRA Registry Verification requirement

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/16/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE ST JOSEPH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 17 EAST 8TH AVENUE SPOKANE, WA 99202		
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F 496	Continued From page 60 Per review of 5 newly hired employees' files, Staff #X and Staff #Y did not have required registry verification showing they met competency evaluation requirements. In an interview on 9/12/13 at 8:35 a.m., Staff #Z confirmed the staff in charge of recruiting and performing the registry verification did not realize verification was required for nursing assistants. The facility did not ensure newly hired nursing assistants met competency requirement.	F 496	4) How the nursing home plans to monitor its performance to make sure that solutions are sustained: <ul style="list-style-type: none"> PSJCC HR representative will perform manual reviews to ensure OBRA Registry Verification completed Employee sample of required background checks will be conducted during PSCS Mock Survey process 		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 520	5) Dates when corrective actions will be completed: October 25, 2013 6) The title of the person responsible to ensure correction: <p>██████████ Administrator</p> <p>██████████ VP of Human Resources</p>		

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F 520	<p>Continued From page 61</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure their Quality Assessment and Assurance (QAA) committee identified and effectively addressed relevant care issues which affected the quality of life and quality of care for 114 facility residents. Findings include:</p> <p>Refer to the following: F241 Dignity and Respect for Individuals, F242 Self-Determination and Participation, F250 Social Services, F309 Necessary Care and Services, F312 ADL-Dependent Resident Receives Services, F314 Pressure Ulcers, F325 Maintain Nutritional Parameters-Weight Loss, F329 Unnecessary Drugs, F333 Significant Medication Errors.</p> <p>In an interview on 9/12/13 at 1:00 p.m., the Administrator stated the QAA committee identified areas of concern based on information submitted to the corporate office from the facility and then corporate determined what issues to be addressed by the committee. The administrator said any staff was welcome to bring forward issues of concern, but most of the issues discussed were determined by corporate.</p> <p>During the above interview, the surveyor discussed the concerns related to maintaining nutritional parameters (F325). The administrator said that Staff #N (Registered Dietician) and Staff #P (Dietary Manager) were normally present at all the QAA meetings, but no issues had been brought forward by them regarding weight discrepancies or weight loss. The surveyor informed the Administrator that during an</p>	F 520	<p>1) How the nursing home will correct the deficiency as it relates to the resident:</p> <ul style="list-style-type: none"> • No residents identified <p>2) How the nursing home will act to protect residents in similar situations:</p> <ul style="list-style-type: none"> • No residents identified <p>3) Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p> <ul style="list-style-type: none"> • Quality Assurance Policy reviewed and updated to include monthly and quarterly meeting schedule • Quality Assurance Committee meeting model and schedule revised to include both monthly and quarterly meetings to ensure more consistent review and oversight of resident quality and safety outcomes. This model is more consistent with QAPI requirements and includes, but is not limited to; review of internal audit results, identification of quality outcomes and trends, measureable goals, national benchmarks and targets, SBAR action plans, and follow-up guidelines • Compliance, Safety, and Risk Management section of the Quality Assurance Committee broadened to include compliance monitoring, regulatory survey results, and trends in deficiencies impacting patient safety 	

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F 520	Continued From page 62 interview with a staff member (who wished to remain anonymous), it was confirmed one of the scales on the main floor was still being used though it was not working properly. The staff member said it was weighing residents at a 12 pound difference. Also, in the above interview, the surveyor discussed the concerns related to significant medication errors (F333). The administrator stated the issues with medication errors were identified in QAA previously and a plan to track and monitor medication errors was supposed to be implemented. However, per review of investigations of medication errors this was not occurring. The facility did not have an effective system to identify quality of care concerns to address in the QAA committee and did not have an effective plan in place to ensure plans for improvement were implemented once concerns were brought forward.	F 520	4) How the nursing home plans to monitor its performance to make sure that solutions are sustained: <ul style="list-style-type: none">• CMS Quality Measures, survey results, and facility sub-committee activities will be reviewed as part of the on-going QA program• PSCS Mock Survey process implemented in 2013 which identifies deficient practice using QIS worksheets and Critical Element tools• New ABAQIS application to be implemented in January 2014 for on-going Quality Assurance Process Improvement (QAPI) planning 5) Dates when corrective actions will be completed: October 25, 2013 6) The title of the person responsible to ensure correction: ██████████, Administrator		