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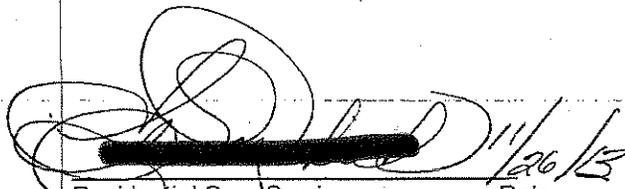
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

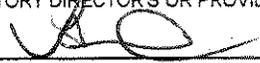
PRINTED: 11/26/2013  
FORM APPROVED  
OMB NO. 0938-0391

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  R 11/18/2013
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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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(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
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{F 000}	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Revisit Quality Indicator Survey conducted at Providence St Joseph Care Center on 11/14/13, 11/15/13, and 11/18/13. A sample of 35 residents was selected from a census of 106. The sample included 24 current residents and the records of 11 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>██████████ R.N., B.S.N.  ██████████ R.N., B.S.N.  ██████████ M.S.W.</p> <p>The survey team is from:</p> <p>Department of Social &amp; Health Services  Aging &amp; Long-Term Support Administration  Division of Residential Care Services  316 West Boone Avenue, Suite 170  Spokane, Washington 99201</p> <p>Telephone: (509) 323-7302  Fax: (509) 329-3993</p> <p>  Residential Care Services  Date 11/26/13</p>	{F 000}	<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><b>RECEIVED</b>  DEC 13 2013  DSHS ADSA RCS  SPOKANE WA</p>	1/16/13
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  	TITLE Administrator	(X6) DATE 12/13/13
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 333} SS=D	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</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 2 of 7 residents reviewed for anti-coagulant therapy (#386, 464) in a sample of 35 were free from significant medication errors. Findings include:</p> <p>1. Per record review, Resident #386 had diagnoses including an [REDACTED] and a recent [REDACTED]. Physician orders included [REDACTED] (anti-coagulant) to reduce the risk of further [REDACTED] and periodic laboratory tests to include INR (test to check blood clotting time used to determine [REDACTED] dosage). Review of the resident's October/November 2013 Medication Administration Record (MAR) and clinical record revealed the following. There were physician orders for [REDACTED] milligrams (mg) daily beginning 10/29/13 with the next INR to be drawn 10/31/13. On 10/31/13, the INR was [REDACTED]. An INR result less than 2.0 indicates that the blood clots too easily and increases the risk for [REDACTED] caused by blood clots. Staff #O administered [REDACTED] mg on the evening shift. There were no new physician orders for [REDACTED] obtained for 4 days, 10/31-11/3/13 to address the low INR. On 11/4/13, the resident's INR was [REDACTED] indicating the resident as not receiving enough medication to reduce the risk of [REDACTED]. The</p>	{F 333}	<p><b>1) How the nursing home will correct the deficiency as it relates to the resident:</b></p> <ul style="list-style-type: none"> <li>• Investigation involving resident #386 updated to include interviews, summary and conclusion addressing: <ul style="list-style-type: none"> <li>○ Why error was not discovered earlier</li> <li>○ How error was discovered</li> <li>○ Origin "cause" of transcription error</li> <li>○ Corrective action taken</li> </ul> </li> <li>• Investigation involving resident #464 updated to include interviews, summary and conclusion addressing: <ul style="list-style-type: none"> <li>○ Why there was a lack of written orders to hold and re-start aspirin &amp; [REDACTED]</li> <li>○ What was origin "cause" of omission of medication</li> <li>○ Corrective action taken</li> </ul> </li> <li>• Residents #386 and #464, INR's and Anticoagulant medications are being provided as per physician orders.</li> </ul> <p><b>2) How the nursing home will act to protect residents in similar situations:</b></p> <ul style="list-style-type: none"> <li>• See submitted POC Annual Survey 9/16/13</li> <li>• Current records for all residents receiving Anticoagulant therapy reviewed for accuracy</li> </ul>	

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{F 333}	<p>Continued From page 2</p> <p>nurse practitioner ordered [REDACTED] mg and [REDACTED] (rapid acting anti-coagulant) to be administered by subcutaneous [REDACTED] every 12 hours until the resident's INR was greater than/equal to 2.0 for 48 hours. The resident required [REDACTED] injections through 11/7/13.</p> <p>Review of the facility investigation confirmed daily [REDACTED] doses were omitted on 11/1, 11/2, and 11/3/13. On 10/31/13, Staff #N, the day shift nurse, obtained the low INR result and informed Staff #P, the evening nurse, that she needed to obtain new [REDACTED] orders from the nurse practitioner. Staff #O could not recall if she followed up or not.</p> <p>The facility investigation did not determine why other licensed nurses administering medications did not find the medication error or how Staff #N discovered the error on 11/4/13.</p> <p>Review of the November 2013 staffing schedule revealed Staff #N worked day shift on 10/31/13 and returned to work on 11/4/13, the day she discovered the medication error. Staff #O did not work again between 11/1-4/13.</p> <p>During observation and interview on 11/15/13 at 10:50 a.m., the resident stated she had a [REDACTED] and was receiving therapy services. She did not recall receiving medications by injection.</p> <p>During interview on 11/15/13 at 11:25 a.m., Staff #J stated on 10/31/13, the routine medications on the November 2013 MARS had already been reconciled. Since [REDACTED] doses were not routine, Staff #P should have transcribed the [REDACTED] dosage onto the November MAR, as well as obtained a new medication dosage order. Staff #J stated she did not interview the other licensed nurses who also omitted the [REDACTED] because she was focused on determining the root cause of the error on 10/31/13.</p>	{F 333}	<ul style="list-style-type: none"> <li>• Nurse managers received additional training on management of medication errors to include:             <ul style="list-style-type: none"> <li>○ Definitions of "Significant vs non-significant Medication Errors"</li> <li>○ Three general guidelines that must be followed when assessing medication error to include: Resident condition, drug category, and frequency of errors</li> <li>○ List of specific drugs categories that are classified as significant due to having Narrow Therapeutic Index (NTI) which includes Anticoagulants: [REDACTED]</li> <li>○ Using professional judgment and above noted guidelines in determining "Serious Disregard for Consequences" as outlined in "Purple Book" Appendix C</li> </ul> </li> </ul>	

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{F 333}	<p>Continued From page 3</p> <p>The omission of [REDACTED] for 3 days placed the resident at risk for further [REDACTED]</p> <p>2. Per record review, Resident #464 had acute mental status changes. Physician orders for anti-coagulants included daily doses of [REDACTED] (rapid-acting anticoagulants) and [REDACTED]</p> <p>Per record review, on 10/16/13, Staff #P, the health unit coordinator, received verbal instructions to hold aspirin and other "blood thinners" for an upcoming diagnostic test. Staff #P reviewed these verbal instructions with Staff #Q, the licensed nurse. Staff #Q reviewed the instructions with the pharmacist and confirmed that both Aspirin and [REDACTED] should be held. There were no physician orders written.</p> <p>Per record review, the word "Hold" was written on the October 2013 MAR for both the Aspirin and [REDACTED] for the dates of 10/17/13 through 10/23/13. Details of the appointment were written on the next page of the MAR with instructions to hold aspirin and blood thinners.</p> <p>Per record review, on 10/17/13 the test was canceled but the [REDACTED] and Aspirin were held until 10/24/13, an omission of 7 days.</p> <p>Review of the facility investigation revealed no information about the lack of physician orders to hold and restart the medications.</p> <p>In an interview on 11/18/13, Staff #I stated additional staff education was completed 11/15/13 regarding obtaining written instructions/orders for procedures, including specific dates for stopping and restarting medications.</p> <p>The failure to document written medication orders related to the planned diagnostic test contributed to the resident missing anticoagulant medication, placing him at increased risk of [REDACTED]</p>	{F 333}	<p><b>3) Measures the nursing home will take or systems it will alter to ensure that the problem does not recur:</b></p> <ul style="list-style-type: none"> <li>• See submitted POC Annual Survey 9/16/13</li> <li>• Anticoagulation and INR procedure reviewed and revised to include: <ul style="list-style-type: none"> <li>○ Updated process flow outlining roles and responsibilities for management of anticoagulation therapy (new and current orders)</li> <li>○ Anticoagulant monitoring sheet which includes INR results, new order, and next INR due date.</li> <li>○ INR due date also documented and highlighted on the residents MAR</li> <li>○ On-going INR auditing process implemented</li> </ul> </li> <li>• All licensed nursing staff have been in-serviced on revised INR and Anticoagulation procedure to include; <ul style="list-style-type: none"> <li>○ Roles and responsibilities in obtaining INR</li> <li>○ Anticoagulation monitoring sheet</li> <li>○ Communication with physician and obtaining new orders</li> </ul> </li> </ul>	

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{F 353} SS=E	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>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.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</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 staffing availability to provide care and services in a timely manner to meet the care needs of each resident. Affected were 11 residents (#1, #3, #4, #6, #16, #24, #58, #127, #161, #163, #374 ) on the Garden level in a sample of 35. Findings include: The facility is licensed for 152 beds with resident rooms on 3 levels. The Garden level has a capacity for 66 residents. During the survey, 61 residents resided on the Garden level. The</p>	{F 353}	<ul style="list-style-type: none"> <li>○ Updating MAR process</li> <li>○ INR auditing and tracking</li> <li>● Process for end of month orders being reviewed and updated if appropriate to provide for accurate medication administration records for the next month with staff education as needed.</li> </ul> <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"> <li>● See submitted POC Annual Survey 9/16/13</li> <li>● Review of INR/Anticoagulant process in place to identify ongoing issues with a goal of 100% compliance.</li> <li>● Ongoing issues will be thoroughly investigated to include establishment of root cause and appropriate actions implemented</li> <li>● Medication errors will be reviewed and tracked monthly by Quality Committee</li> </ul> <p>5) Dates when corrective action will be completed:  January 13, 2013</p> <p>6) The title of the person responsible to ensure correction:  ██████████ Administrator</p>	

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{F 353}	<p>Continued From page 5</p> <p>residents are long-term care residents who are dependent of staff for their care, including transfers, bathing, dressing, toileting, and personal care. Based upon review, 22 of the 61 residents required assistance of 2 staff for transfers. An additional 4 residents required assistance of 2 staff, but did not get up daily per their preference.</p> <p>1. Per record review, Resident #4 had no short term memory problems and was able to express her needs. The resident required extensive assistance from staff for toileting and transfers. The resident was at risk for development of pressure ulcers and had a history of Stage I pressure ulcers (redness with no skin breakdown) to her coccyx.</p> <p>On 11/14/13 at 2:42 p.m., the resident was observed in the doorway of her room with her call light on. The resident's eyes were watering and she started to cry and stated her bottom "hurt so bad" and she needed to go to the bathroom.</p> <p>Shortly after, Staff #A came down the hallway to the resident's room and told the surveyor "the resident was fine and nothing was wrong, they just have a [REDACTED] infection)." Then Staff #B entered the resident's room with the sit to stand transfer lift and asked the resident why her bottom hurt. The resident said it hurts when she sits too long. Both of the staff, #A and #B came out of the room quickly and stated the resident no longer had the urge to go to the bathroom and left her in the wheel chair to go assist another resident that was also a 2 person assist. The resident remained in the wheel chair and her light remained on.</p> <p>At 2:52 p.m., Resident #4's call light remained on and she wheeled out from her room and went down to the end of the hallway to Staff #B and</p>	{F 353}	<p><b>1) How the nursing home will correct the deficiency as it relates to the resident:</b></p> <ul style="list-style-type: none"> <li>Resident #4 will be reassessed and care plan reviewed/updated to ensure resident ADL preferences, transfer, skin interventions, and toileting needs are accurate.</li> <li>Resident #179 will be reassessed and care plan will be reviewed/updated to ensure appropriate interventions are in place to address resident safety and behavior needs and preferences</li> <li>Resident #3 care plan will be reviewed/updated to ensure residents ADL and bathing choices are accurate and being offered</li> <li>Resident #374 care plan will be reviewed/updated to ensure appropriate interventions are in place to address residents toileting and safety needs and preferences</li> <li>Residents #1, 6, 16, 24, 58, 127, 161, and 163 care plans reviewed/updated to ensure bathing preferences /schedules are accurate and being honored.</li> <li>All appropriate staff will be informed of updates and requirements to follow care plans for residents impacted</li> </ul>	

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{F 353}	<p>Continued From page 6</p> <p>requested assistance again and then went back to her room. At 3:00 p.m., the resident wheeled back into the hallway and Staff #D asked the resident if she had been taken to the bathroom yet and the resident stated "No." From 3:05 p.m. to 3:18 p.m., the resident was back in her room in the wheel chair, without assistance from staff. The resident came back out of the room again at 3:18 p.m. and her eyes were watering and she stated "there is not enough staff and they are so busy." The resident said her bottom "hurt so bad" and she had "wet her pants" yesterday because she did not get help fast enough from staff.</p> <p>At 3:20 p.m. on 11/14/13, a housekeeper walked by and the resident let her know that she needed to go to the bathroom. At 3:26 p.m., 44 minutes later, Staff #A and #B assisted the resident with toileting and getting into bed.</p> <p>At 4:25 p.m., the surveyor and Staff #A checked the resident's skin. The resident had no red areas. During interview, the resident was calm and said she was no longer uncomfortable. She pointed to her [REDACTED] buttock and stated that area got sore and red if she sat too long. She was dressed in a gown and stated she ate dinner in bed. She usually got up about 10:00 a.m. and went back to bed before dinner. She stated if she got back up for dinner, she wouldn't be able to get assistance from staff to go back to bed until after 7:00 p.m. and her bottom would hurt.</p> <p>In an interview after resident observation, Staff #A stated she was assigned 12 residents that shift. Earlier in the shift, she knew Resident #4 needed to to the bathroom. At the same time, she was making a bed, then another resident was incontinent and required the assistance of 2 staff for transfers. By the time she checked back, the resident had lost the urge to go, so she went to</p>	{F 353}	<p><b>2) How the nursing home will act to protect residents in similar situations:</b></p> <ul style="list-style-type: none"> <li>• See submitted POC Annual Survey 9/16/13</li> <li>• One extra Garden Level NAC added to evening shift</li> <li>• Housekeeping staff will be instructed on alternative was to seek assistance for resident care needs</li> </ul> <p><b>3) Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</b></p> <ul style="list-style-type: none"> <li>• See submitted POC Annual Survey 9/16/13</li> <li>• In collaboration with outside consultant and performance improvement team (PIT) comprised of direct care and licensed staff from all shifts, examining components and develop action plans of our staffing model and resident needs based on following criteria:             <ul style="list-style-type: none"> <li>○ Resident acuity and need for assistance with transfers</li> <li>○ Staff assignments and breaks</li> <li>○ Staff distribution</li> <li>○ Dining times and residents' need for assistance</li> <li>○ Shower/bathing schedules</li> </ul> </li> </ul>	

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{F 353}	<p>Continued From page 7 assist another resident.</p> <p>On 11/14/13 at 4:30 p.m. on the Garden Level, Staff #B stated she was assigned to 13 residents which 5 of the residents were 2 person assist. She stated the bath aide had 3 evening showers that were 2 person assist so a nursing assistant (NAC) had to be taken from answering call lights on the floor to assist the bath aide with transfers to and from the shower chair each time. Staff #C joined the interview and stated that the lack of staffing affected the care of the residents, in which Staff #B agreed. Staff #C also stated having 12 to 13 residents for one NAC was too many. Staff #B stated Resident #4 was not assisted as quickly as they would of liked and there was another resident they had to prioritize even though they both needed assistance urgently and they were both a 2 person assist.</p> <p>On 11/14/13 at 4:35 p.m., Staff #D, #E, #F, and #G were interviewed regarding staffing on the Garden level that evening shift. Staff #F stated there were a total of 5 NAC's and 1 bath aide on the Garden level that evening. Staff #D had 12 residents with 2 who needed a 2 person assist, #F had 12 residents with 7 who needed a 2 person assist, #G had 11 residents with 4 who needed a 2 person assist totaling 35 residents with 12 who needed a 2 person assist.</p> <p>Staff #D stated when they are minus one or more regular scheduled NAC staff members they can have up to 16 residents and that "gets to be a little much but they do the best they can."</p> <p>Staff #E, the bath aide, stated she would be reassigned to resident care as often as every 3 shifts due to not having enough staff.</p> <p>Staff #F stated when they are minus one or more regularly scheduled staff members, the assigned bath aide would be re-assigned to do patient care and they would "try to chip in to get</p>	{F 353}	<ul style="list-style-type: none"> <li>○ Resident preferences for care and services (awake time, bedtime, naps, toileting needs, shower schedules &amp; other)</li> <li>○ Staff roles and responsibilities (including Licensed Nurse roles in supervision and assisting with care and services)</li> <li>● Action plan developed and implemented as result of PIT prior to compliance date</li> <li>● Call light policy and procedure re-reviewed and revised if necessary to include; management of call light activation, staff responsibility during response, and minimal response time requirements</li> <li>● All Garden Level clinical staff will be re-trained on call light policy to include; <ul style="list-style-type: none"> <li>○ Management of call light activation</li> <li>○ Staff responsibility during response</li> <li>○ Minimum response times</li> <li>○ Auditing and tracking</li> </ul> </li> </ul>		

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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 353}	<p>Continued From page 8 baths done." On 11/15/13 at 8:35 a.m., Staff #H stated when the staff member who was scheduled to bathe the residents is re-assigned to do patient care on the floor, the scheduled baths usually do not get done.</p> <p>2. Resident #179, per record review, required extensive assistance with care and had a diagnosis of [REDACTED] with [REDACTED] decline, history of [REDACTED] and chronic [REDACTED]. On 11/14/13 at 2:49 p.m., Resident #179 was in her room with the light off and door partially open calling out a name over and over, which could be heard from the hallway. Multiple staff walked by the room several times and did not respond. The resident called out continuously until 2:51 p.m., and was then quiet until 3:05 p.m. From 3:05 p.m. to 3:26 p.m. the resident called out "mom" several times as staff continued to walk by the room. At 4:29 p.m., the resident called out "help" several times and staff walking by did not stop to check on the resident. On 11/18/13 at 1:56 p.m., Staff #N stated the resident had a history of self-harming tendencies and called out often. Staff #N stated in the past she had found the resident several times with the call light cord wrapped around her neck. Staff #N stated when the resident called out staff was supposed to talk with resident, turn on her music and check/change her brief. These approached/interventions were not observed during the multiple observations.</p> <p>3. On 4/18/13 at 1:45 p.m., Resident #3 stated he was previously scheduled for evening shift showers, but his showers on evening shift were "hit and miss" because there would not be a staff</p>	{F 353}	<p><b>4) How the nursing home plans to monitor its performance to make sure that solutions are sustained:</b></p> <ul style="list-style-type: none"> <li>• See submitted POC Annual Survey 9/16/13</li> <li>• As part of ongoing quality plan, resident acuity and staffing needs will be reviewed monthly related to admissions and discharges and the criteria noted under the PIT plan</li> <li>• Call light response will be audited and monitored for compliance with call light policy and response times</li> </ul> <p>5) Dates when corrective action will be completed:  January 13, 2013</p> <p>6) The title of the person responsible to ensure correction:  [REDACTED] Administrator</p>		

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{F 353}	<p>Continued From page 9</p> <p>member designated to do showers. Recently, his shower schedule changed to day shift and he was receiving more showers.</p> <p>In an interview on 11/18/13 at 1:00 p.m., Staff #K, the Garden Level manager stated the usual staffing for the days shift was 7 NACs and a bath aide. The usual staffing for the evening shift was 6 NACs, with one of those designated each shift as the bath aide. If only 5 NACs were scheduled, each NAC was responsible for bathing. Staff #K stated she considered factors including timeliness of resident bathing to evaluate adequate staffing.</p> <p>Review of the Garden level staffing for day/evening shift between 11/7/13 to 11/17/13, a total of 11 days, revealed the following.</p> <p>On 4 days, day shift staffing was only 6 NACs and 1 bath aide.</p> <p>On 3 days, evening shift staffing was only 5 NACs with no designated bath aide.</p> <p>On 1 day, evening shift staffing was only 4 NACs with no designated bath aide.</p> <p>Review of the bathing records for 12 residents on both the Main and Garden level scheduled for bathing twice a week between 11/7/13 to 11/17/13 revealed 7 of 12 residents (#1, 6, 16, 24, 58, 161, and 163) were not bathed twice weekly and had 5-9 days between bathing during that time period.</p> <p>4. On 11/18/13 at 2:35 p.m. in the Garden Level hall, a housekeeper came out of Resident #374's room, stating the resident was taking herself to the bathroom. There were no staff visible. The housekeeper found Staff #L in another resident's room. Staff #L advised the housekeeper she couldn't leave and suggested she go back and ask the resident to wait for help. The housekeeper responded the resident wasn't listening to her. The housekeeper returned to the</p>	{F 353}		

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{F 353}	Continued From page 10 resident's room and stated the resident was now in the bathroom by herself. At that point, a non-licensed staff came down the hall and found a licensed nurse from another section who assisted the resident in the bathroom. The care plan on the inside of the resident's closet indicated the resident was not to be left alone in the bathroom. In an interview after the observation, Staff #L stated the evening shift staffing that day was 5 NACs and no bath aide. The facility's failure to ensure sufficient staff placed residents at risk for discomfort, avoidable injury, and a diminished quality of life.	{F 353}			