STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505515	A. BUILDING _____ B. WING _____	04/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLYMPIA MANOR	1811 EAST 22ND AVENUE OLYMPIA, WA 98501

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F 000	INITIAL COMMENTS This report is the result of an unanncounced Quality Indicator Survey conducted at Olympia Manor on 4/1, 4/2, 4/3, 4/4, 4/7, 4/8, 4/9, 4/10, 4/11/14. A sample of 28 residents was selected from a census of 18. The sample included 18 current residents and the records of 10 former and/or discharged residents. The survey was conducted by: Gilda Warden, EdD, RN-BC Ruth Futch, RN, BSN, MBA Phan Pham, RN, BSN The survey team is from: Department of Social and Health Services Aging and Disability SErvices Administration Residential Care Serives, Distict 3, Unit C 6639 Capitol Boulevard SW Tumwater, Washington 98501 Telephone: (360) 664-8420 Phan Pham 4-23-14 Signature Date	F 000	Disclaimer Clause This plan of correction is being submitted in accordance with specific regulatory requirements and should not be construed as an admission of guilt or agreement with any of the deficiencies on the HCFA 2567; nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for alleged deficiencies The facility reserves the right to challenge in legal proceedings, all deficiencies statements, findings, facts, and conclusions that form the basis of the deficiency. RECEIVED MAY 02 2014 DSHS/ADSA/RCS	5-8-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Lauren M. Lawson | NHA | 5-1-14

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ier safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing 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 /s following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued igram participation.

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F 000	Continued From page 1	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced	F 157	F-157 **How the nursing home will correct the deficiency as relates to the resident:** Resident 9's physician was notified of incident of patient Resident 27's physician was notified of weight changes per perimeters set by the physician. **How the nursing home will act to protect residents in similar situations.** An audit was complete by the Director of Nursing to ensure any resident with weight changes in perimeters set by the physician was reported to the physician or incidents for the last thirty days notification to the physician was obtained.	5-6-14

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F 157	Continued From page 2 by: Based on observation, interview and record review it was determined that the facility failed to notify the physician regarding a fall or weight changes for 2 of 6 Sampled Residents (#9 & 27)) reviewed for either accidents or medication use of the 28 residents who were included in the Stage 2 review. This prevented the physician from being aware the reisdent experienced an injury that had the potential to require physician intervention and/or to have an opportunity to alter the resident's treatment plan. Findings include: Refer to F 309 for further information, observations, interviews and record review related to failure to consistently monitor Resident #9 after a fall. A facility "Event & Occurrence Report" dated 3/16/14 identified staff discovered Resident #9 on the floor in his room. The resident reported bumping his head. The report documented the nurse found the resident had a 2 centimeter (cm) x 2 cm bump on the scalp approximately one inch behind the hairline on the right side of the head. A section on the front of the form contained a space to indicate when staff notified the physician and to document any orders received. This section, left blank, did not identify staff informed the physician Resident #9 fell. Nursing notes did not contain evidence staff notified the physician of the fall and injury that occurred. On 4/9/14 at 11:09 a.m. the Director of Nursing Services (DNS) confirmed the investigation did	F 157	**Measures the nursing home will take or the systems it will alter to ensure that the problem does not occur:** An education was complete with licensed staff to ensure the facility is notifying the physician of weight changes per perimeters set by the physician and incidents in the facility. **How the nursing home plans to monitor its performance to make sure that solutions are sustained:** An audit will be performed weekly by the Director of Nursing and/or designee regarding contact physician regarding weight changes in the perimeters set by the physician and incident reporting. Any identified issues will be corrected immediately and any trends will be turned in to the Quality Assurance committee for the next sixty days or further as determined by the Quality Assurance Committee. **The title of the person responsible to ensure correction.** Director of Nursing	

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F 157	Continued From page 3 not identify staff notified the physician. The DNS reported staff would have notified the physician during cluster calls (designated times to contact the resident's physician) and the facility kept a log of physician notifications and what information staff discussed with the physician. The DNS reviewed cluster call records for the period of time following Resident #9's fall and reported call records did not indicate staff informed the physician the resident fell and bumped his head. The facility did not provide further evidence staff notified the physician regarding Resident #9's fall. Refer to F 309 for failure to consistently monitor Resident #9 following the fall. RESIDENT #27 Refer to F 281 for failure to follow physician orders and F 309 for additional information regarding failure to monitor Resident #27's medical condition. Resident #3 re-admitted to the facility on [redacted]14 following hospitalization for fluid accumulation between the lining of the outside of the lungs and the wall of the chest . A hospital Discharge Summary dated 11/9/13 documented Resident #27 had multiple diagnoses that included a severe to critical heart condition; irregular heart rhythm; history of CHF and high blood pressure. A physician order dated 11/11/13 directed staff to monitor Resident #27's weight twice a week and to notify the physician of weight gain or loss of greater than 2 lbs.	F 157		

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F 157	Continued From page 4 Resident #27's medical record did not contain evidence staff followed physician orders to notify the physician of weight changes greater than 2 lbs on eight occasions noted between 1/8/14 through 4/6/14. This placed the resident at risk to not have timely intervention by the physician.	F 157		
F 205 SS=D	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 205	F-205 **How the nursing home will correct the deficiency as relates to the resident:** Resident 52 was educated on the bed hold policy. **How the nursing home will act to protect residents in similar situations.** Social Service Director and Business Office Manager received an education on Bed Hold policy	5.6.14

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F 205	Continued From page 5 review it was determined that the facility failed to consistently provide required written notice of duration of bed-hold policies upon discharge to the hospital for 1 of 3 Sampled Resident (#52) reviewed for admission, transfer and discharge of the 28 residents who were included in the Stage 2 review. This failure prevented the resident or surrogate decision maker from having an opportunity to hold the resident's bed throughout the hospitalization to ensure they could return to the facility. Findings include: Resident #52 admitted to the facility from a hospital on [redacted]13 with multiple medical conditions. An Admission Minimum Data Set assessment (MDS, required assessment tool) dated 12/16/13 identified the resident discharged to the hospital and readmitted back to the facility five times between [redacted]13 and [redacted]14. Each MDS identified the resident did not have any cognitive impairment, speech or hearing difficulties. On 4/7/14 at 11:15 a.m. Staff MR confirmed Resident #52 had multiple admissions and discharges to the facility. On 4/8/14 at 7:38 a.m. Resident #52 sat on the edge of the bed in the room and reported the facility did not always provide information regarding bed-hold policies before being sent to the hospital. The resident also reported he/she wanted to be notified about the bed-hold policy each time. Resident #52 reported sometimes he/she could not always make a decision regarding bed-hold when ill, and when unable, a family member could then make the decision.	F 205	**Measures the nursing home will take or the systems it will alter to ensure that the problem does not occur.** Staff received an education on the bed hold policy and to ensure we are offering upon to discharge to the hospital and/or LOA situations **How the nursing home plans to monitor its performance to make sure that solutions are sustained.** An audit will be performed weekly by the Social Service Director and/or designee to ensure bed hold policy is reviewed and given to resident. Any identified issues will be corrected immediately and any trends will be turned in to the Quality Assurance committee for the next sixty days or further as determined by the Quality Assurance Committee. **The title of the person responsible to ensure correction.** Social Service Director	

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F 205	Continued From page 6 After one hospitalization, the resident reported the facility readmitted him/her to a different room. On 4/7/14 at 11:03 a.m. the CRN reported Staff SSD had responsibility to inform residents about bed-hold policy. On 4/7/14 at 11:11 a.m. LN C reported Staff BOM had the responsibility to inform regarding bed-hold policies. On 4/7/14 at 11:15 a.m. Staff BOM reported all residents signed a form on admission to identify if they want to be notified of bed-hold. Staff BOM showed me a copy of a "Bed-Hold Agreement" signed by Resident #52 on [redacted]13. The form stated "It is the policy of this facility to offer an opportunity to hold the bed you are currently occupying. A representative of the facility will contact you or your responsible surrogate party to offer them a bed-hold (unless completed at the time of transfer). No bed will be held open without bed-hold authorization .... " The facility policy also stated without prior agreement the bed would not be held for more than 24 hours. Staff BOM reported signing the form indicated Resident #52 wanted to be informed of bed-hold policy each time he/she discharged to the hospital. On 4/7/14 at 11:18 a.m. the BOM reported the SSD or the nurse should offer a resident opportunity to hold the bed if sent to the hospital if the form indicated they wanted to be informed. On 4/7/14 at 11:23 a.m. LN C reported every time a resident went to the hospital, nursing completed a "Resident Transfer Form." A section of the form	F 205		

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F 205	Continued From page 7 included a checkbox to indicate staff informed and provided a copy of the bed-hold policy to the resident at the time of transfer. LN C also reported if a resident could not make a decision at the time "someone" (another staff) would call the surrogate decision maker. LN C showed documentation nursing staff provided bed hold information when Resident #52 transferred to the hospital on [redacted]/14 and [redacted]14, two of five times the resident went to the hospital. On 4/7/14 at 11:27 a.m. during joint interviews with the BOM and the SSD reported the following: The SSD reported she didn't contact resident decision makers regarding bed-hold and thought the BOM would make the contact if a resident transferred from the facility for more than 24 hours. The BOM reported "It is my understanding" the SSD contacted the family regarding the bed hold policy. The SSD reported if she didn't contact the family the DNS or BOM would contact them. Following a request for bed-hold documentation for each of Resident #52's hospital discharges, Staff MR could not locate documentation to indicate the facility provided Resident #52 or the resident's surrogate decision maker had an opportunity to exercise their right to hold the resident's bed when transferred to the hospital on [redacted]13; [redacted]13 or [redacted]14. The facility Policy and Procedure for bed-hold stated if the bed hold agreement was not completed at the time of discharge social service	F 205		

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F 205	Continued From page 8 staff would contact the resident's responsible party or surrogate regarding their choice of holding the bed the next day. On 4/8/14 at 7:50 a.m. the DNS reported the facility did not have further information to provide regarding bed-holds for Resident #52 and reported being aware the facility did not follow their policy. Facility staff did not articulate a clear understanding or implement facility policy and procedure regarding bed hold notification to ensure Resident #52 or the surrogate decision maker were informed of duration of bed-hold policy at the time of all discharges to the hospital. This prevented the resident or decision maker from making an informed choice regarding holding the bed before transfer or discharge to the hospital.	F 205		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to report an allegation of abuse for 1 of 3 Sampled Residents	F 226	F226 **How the nursing home will correct the deficiency as relates to the resident:** Resident 60's allegation was investigated and called into the state immediately when the facility was aware of allegation	5-6-14

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F 226	Continued From page 9 (#60) reviewed for abuse of the 28 Residents who were included in the Stage 2 review. This placed the resident at risk of further potential abuse or neglect. Findings include: On 4/3/14 at 2:25 p.m. interview with Resident #60 revealed the resident believed a staff member took a picture of Resident #60 while in the shower. "I thought the person who was taking pictures of me was talked to and was told that couldn't use a cell phone. I thought that person was taking pictures of me naked. I will work with that staff as long as that staff doesn't have a cell phone handy. So, I didn't shower today because I was too upset that this staff (OT) is here." On 4/4/14 at 9:40 a.m. an interview with the Director of Nursing Services (DNS) "Resident #60 doesn't like people in the room. Resident #60 is a loner, doesn't like folks around. Doesn't like the door open. We take pictures for the medication administration record (MAR) and Resident #60 refused. I have not been told about this allegation by Resident #60." At 10:50 a.m. an interview with DNS who reported an investigation was being done on behalf of Resident #60 for newest allegation of being possibly "pictured while naked" by a CNA. On 4/9/14 at 11:10 a.m. Event and Occurence Report was provided by the DNS. Investigation done by facility on 4/4/14 regarding allegation by Resident #60 on 4/2/14. Resident #60 stated a staff member had taken a picture of Resident #60 while resident was nude in the shower room. The	F 226	**How the nursing home will act to protect residents in similar situations** An interview with residents was completed to ensure unknown allegations of abuse were reported and investigated. **Measures the nursing home will take or the systems it will alter to ensure that the problem does not occur:** Therapy Department was educated regarding abuse reporting to the facility on 04/07/14 **How the nursing home plans to monitor its performance to make sure that solutions are sustained:** An audit will be performed weekly by Social Service Director and/or designee to ensure that the staff are aware of the abuse reporting. Any noted issues will be corrected immediately and any trends will be turned in to the Quality Assurance committee for the next sixty days or further as determined by the Quality Assurance Committee.	

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F 226	Continued From page 10 Event and Occurence review indicated an interview with the Director of Rehabilitation (PT) was done and PT was informed by Resident #60 on 4/2/14 that staff OT was using the cell phone while assisting Resident #60 in the shower. The statement by PT acknowledged that PT "neglected to forward this allegation to building administrator or DNS." The review of the facility "Abuse Prevention Program" provided by facility on 4/1/14 indicated on page 20, "it is required that you notify your supervisor of all occurrences in order for the facility to provide a safe environment and investigate the occurrence. Failure to notify your supervisor of an occurrence will result in a delayed facility response and can lead to further harm for the resident."	F 226	**The title of the person responsible to ensure correction** Social Service Director F-280	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed	F 280	5-6-14 **How the nursing home will correct the deficiency as relates to the resident:** Resident 18 care plan was revised identifying proper positioning needs. **How the nursing home will act to protect residents in similar situations.** An audit was completed for Residents to ensure proper positioning needs have been identified and addressed on care plans.	

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F 280	Continued From page 11 and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to revise a care plan to identify specific positioning needs for 1 of 4 Sampled Residents (#18) reviewed for Activities of Daily Living (ADLs) and positioning needs of the 28 residents who were included in the Stage 2 review. This had the potential to place the resident at risk for improper body alignment when seated, increased risk to fall if leaning too far forward and increased discomfort. Findings include: A facility admission face sheet indicated Resident #18 admitted to the facility on [redacted]12 with diagnoses that included diabetes, kidney disease, dementia, difficulty walking and neuropathy. Neuropathy results from nerve damage usually in hands and feet that causes weakness and altered sensation of pain, tingling, burning and/or numbness. Required Care Area Assessment Summaries dated 9/22/13 documented the resident often tired and slept more often. A quarterly Minimum Data Set (MDS, required assessment tool) dated 2/25/14 identified Resident #18 had arthritis; history of a stroke and	F 280	**Measures the nursing home will take or the systems it will alter to ensure that the problem does not occur.** Staff received an education to ensure proper positioning needs have been identified and addressed on care plans. **How the nursing home plans to monitor its performance to make sure that solutions are sustained.** An audit will be performed weekly by the Director of Nursing and/or designee to ensure proper positioning needs have been identified and addressed on care plans. Any identified issues will be corrected immediately and any trends will be turned in to the Quality Assurance committee for the next sixty days or further as determined by the Quality Assurance Committee. **The title of the person responsible to ensure correction.** Director of Nursing	

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F 280	Continued From page 12 fractured hip; impaired cognition; required total assistance with all ADLs that included transfers and moving within the facility and used a wheelchair. The assessment also indicated the resident had functional loss of the use of both arms and could not stabilize when transferred between surfaces such as on and off the toilet. A "Device Assessment" for a tilt and space wheelchair dated 10/9/13 documented Resident #18 previously used a standard wheelchair "but sat with forward flexion, falling asleep with forehead" near knees. The assessment documented the resident expressed discomfort in the wheelchair and staff tried a tilt wheelchair to relieve chronic back pain. The assessment identified the tilt wheelchair would help maintain the resident's alignment and decrease pain. The assessment contained a "plan" to maintain the position of the resident upright with meals and to tilt the wheelchair 45 degrees when sleeping. A Plan of Care titled "Fall Management" dated 2/6/14 included an intervention to continue use of a tilt and space wheelchair for body alignment maintenance, positioning and comfort related to chronic lower back pain. An ADL plan of care also identified use of a tilt and space wheelchair for comfort. Care plans did not identify how to position the tilt and space wheelchair to ensure proper positioning and comfort. April 2014 Physician Orders directed staff to administer a narcotic pain medication to Resident #18 at bed time for chronic pain. On 4/7/14 at 10:00 a.m. Resident #18 sat in a wheelchair in the Fireside Room with legs slightly	F 280		

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F 280	Continued From page 13 elevated on footrests. The wheelchair had a tilt bar that indicated the resident reclined 22 degrees in the wheelchair from an upright position. The resident's upper body leaned forward slightly and both eyes were closed. The resident did not awaken when spoken to. On 4/8/14 at 7:05 a.m. the resident sat in the tilt wheelchair in the Fireside Room with eyes open. The wheelchair degree of tilt indicated the resident reclined 15 degrees from an upright position. Resident #18 upper body leaned forward slightly in the chair and the resident's head did not rest on the wheelchair headrest. Both legs were elevated on footrests. On 4/8/14 at 9:30 a.m. Staff PT and the surveyor walked into the Fireside Room to observe Resident #18 in the wheelchair. The wheelchair was in an upright position and the resident's eyes were closed. The headrest tilted to one side and the resident's head did not rest against it. Neither of the resident's legs were positioned inside the leg rests and the back of both lower legs rested on the front edge of footplates. Staff PT immediately tilted Resident #18 to a reclined position and the resident let out a sigh and smiled when leaned back to a 45 degree position. The resident's head rested on the bottom edge of the headrest when reclined and did not cradle the resident's head. Staff PT reported the headrest sometimes needed to be adjusted and had not been informed by nursing it needed to be repositioned. At this time, Staff PT fixed an unsecured and unlatched left leg rest that swung slightly outward and did not align directly in front of the	F 280		

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F 280	Continued From page 14 wheelchair. Staff PT reported Resident #18 should sit upright when dining and be tilted back approximately 45 degrees other times. Staff PT also reported positioning assisted with improving comfort and safety since the resident would slump forward with head on knees and could fall out. Staff PT reported the resident had not fallen out of the wheelchair in the past. On 4/8/14 at 10:03 a.m., when asked how nursing staff knew how to position Resident #18 in the tilt and space wheelchair, Staff PT reported information was discussed during nursing stand up meetings. Staff PT also reported therapy did not revise care plans or identify degree/s of tilt on care plans for residents who used tilt wheelchairs. On 4/8/14 at 10:36 a.m. NA A reported the resident sometimes moved legs and dangled them outside the leg rests or placed heels on the edge of the foot rests. When asked how staff knew how to position Resident #18 in the tilt and space wheelchair, NA A reported "it's in the care plan in the room." NA A asked NA F to show the surveyor the care plan in the resident's room. On 4/8/14 at 10:40 a.m. NA F located the aide directive inside the resident's closet in the room and confirmed the aide directive identified the resident had a tilt wheelchair and did not provide further instructions how to position it. On 4/8/14 at 10:45 a.m., when asked, the DNS did not know if care plans identified specific degrees of tilt for residents who used them. If staff had a question regarding positioning residents in wheelchairs they asked therapy staff.	F 280		

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F 280	Continued From page 15 On 4/9/14 at 8:05 a.m. the surveyor and the DNS looked at Resident #18's position in the tilt wheelchair while seated in the Fireside Room. The resident sat upright with head leaning forward toward the chest and not resting on the headrest. When asked how staff knew how to implement the resident's tilt and space wheelchair, the DNS looked in the record and reviewed the assessment and plan of care. The DNS confirmed the assessment identified the resident leaned forward before and did not locate a plan of care that contained further instructions for staff to identify how to use of the tilt wheelchair to provide the correct positioning for Resident #18. The DNS confirmed additional information should be written on the nursing aide directive. On 4/9/14 at 9:07 a.m. LN B reported care plans were revised during the MDS assessment process. If revisions were needed at other times, nursing staff should revise the care plan. LN B also reported he/she did have involvement with revising care plans and had not been advised of specific implementation directions for Resident #18's tilt and space wheelchair. The facility assessed use of a tilt and space wheelchair on 10/9/13 to assist with maintaining proper positioning and comfort for Resident #18. Staff did not revise the plan of care to include specific information for staff to know how to use the wheelchair such as visual cues for proper positioning, degree/s of tilt or when to tilt the resident to maintain consistent positioning to maximize comfort.	F 280		

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F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined licensed staff failed to consistently follow physician orders related to either obtaining weights, administration of medication for weight gains, notifying the physician of weight changes or obtaining lab work for 3 of 5 Sampled Residents (#s 3, 15 & 27) reviewed for medication use of the 28 residents who were included in the Stage 2 review. These failures had the potential for staff to not readily identify if these residents experienced a decline in medical condition that required timely or immediate medical intervention. Findings include: FAILURE TO FOLLOW PHYSICIAN ORDERS According to Lippincott Manual of Nursing Practice , ninth edition, (Lippincott, Williams & Wilkins), page 17, states "Departure from Standards of Care" includes "Failure to implement a physician's, advanced practice nurse's or physician assistant's order properly or in a timely fashion. According to Smith, Duell and Martin, Clinical Nursing Skills, Sixth Edition, pages 518-521, nurses are to administer medications as ordered by the physician.	F 281	F-281 5-6-14 **How the nursing home will correct the deficiency as relates to the resident:** Resident 3's edema is being monitored according to physician orders. Physician was notified of weight changes per perimeters assigned by the physician. Resident 15 lab work has been ordered per physician orders Resident 27 physician was notified of weight changes per perimeters assigned by the physician. **How the nursing home will act to protect residents in similar situations.** An audit was complete of the Residents in the facility for physician notification of weight changes per the perimeter assigned by the physician, lab work as ordered, and edema monitoring.	

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F 281	Continued From page 17 RESIDENT #3 Refer to F 309 for observations and medical history for Resident #3 related to failure to monitor for edema. A physician order dated 12/1/13 identified for staff to administer a diuretic medication (Lasix) weekly on Sunday if Resident #3 gained 2 pounds in a week. On 12/31/13 the physician directed staff to obtain a weekly weight for Resident #3 on Sunday. 1. Weight records identified staff failed to obtain a weekly weight as ordered on 3/9/14 as indicated to do on the medication record to ensure the resident did not gain 2 lbs since the previous weight taken on 3/2/14. 2. Weekly weight records identified Resident #3 had a 2.8 lb. weight gain between 2/2/14 (127.2 lbs.) and 2/9/14 (130 lbs). The resident's record did not contain evidence licensed staff followed physician orders and administered Lasix on 2/9/14. 3. Weekly weight records identified on 3/24/14 Resident #3 weighed 124.4 lbs. The following week on 3/31/14 staff documented the resident weighed 117 lbs. and on 4/7/14 staff documented the resident weighed 129.2 lbs. On 4/10/14 at 2:52 p.m. the DNS reported the weight of 117 lbs obtained on 3/31/14 was inaccurate. The DNS reported the facility identified a concern with the scale and had the scale re-calibrated and confirmed they did not re-weigh the resident to obtain an accurate weight. The DNS reported staff were looking for	F 281	**Measures the nursing home will take or the systems it will alter to ensure that the problem does not occur.** Staff received an education to ensure all lab work, changes in weight, and edema based on physician parameters are reported immediately to physician.	

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F 281	Continued From page 18 missing weights. Between 3/24/14 and 4/7/14 Resident #3 gained 4.8 lbs. The record did not contain evidence staff administered Lasix for weight gain during the two week period or clarified with the physician if the provider wanted a change in orders. On 4/10/14 at 2:52 p.m. the DNS reported staff should have administered Lasix to Resident #3 on 4/7/14. On 4/11/14 during a meeting beginning approximately 2:15 p.m. the facility did not provide further evidence staff administered Lasix to Resident #3 for weight gains of 2 lbs. as ordered. Failure to follow physician orders to consistently obtain weekly weights or administer Lasix when ordered had the potential for Resident #3 to experience a decline in medical condition related to excess fluid gain. RESIDENT #27 Refer to F 309 for additional information related to Resident #27's medical condition and failure to monitor medical condition. A physician order dated 11/11/13 directed staff to monitor Resident #27's weight twice a week and to notify the physician of weight gain or loss of greater than 2 lbs. Resident #27's medical record did not contain evidence staff followed physician orders to notify the physician of weight changes greater than 2 lbs on eight occasions noted between 1/8/14 through 4/6/14. Weight changes documented the	F 281	**How the nursing home plans to monitor its performance to make sure that solutions are sustained.** An audit will be performed weekly by the Director of Nursing and/or designee complete of the Residents in the facility for physician notification of weight changes per the perimeter assigned by the physician, lab work as ordered, and edema monitoring. Any identified issues will be corrected immediately and any trends will be turned in to the Quality Assurance committee for the next sixty days or further as determined by the Quality Assurance Committee. **The title of the person responsible to ensure correction.** **Director of Nursing**	

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F 281	Continued From page 19 following: Weights recorded on the Medication Record (MAR) noted on 1/8/14 Resident #27 weighed 119.4 lbs and on 1/12/14 weighed 116.8 lbs, a loss of 2.6 lbs. Between 1/12/14 and 1/15/14 the resident gained 3.2 lbs. The February MAR noted Resident #27 lost 2.7 lbs between 2/16/14 and 2/19/14 and lost 4.8 lbs between 2/26/14 and 3/2/14. The Medication Record highlighted for staff to obtain weights on 2/2/14 and 2/9/14 and were blank. The March 2014 MAR documented the resident weighed 121 on 3/5/14. A vital sign record documented Resident #27 weighed 117 on 3/9/14, a gain of 4 lbs. The March MAR documented Resident #27 weighed 117.2 on 3/19/14. The vital sign record identified the resident weighed 119.6 lbs., a gain of 2.4 lbs. April MARs identified the resident weighed 119.8 lbs on 3/30/14 and 122.2 lbs on 4/2/14, a gain of 2.4 lbs. Between 4/2/14 and 4/6/14 Resident #27 lost 4.2 lbs. On 4/9/14 at 1:35 p.m. the DNS reported the physician would have been informed during a cluster call (specified time to discuss resident concerns) and nursing should document notification in nursing notes. The DNS did not provide evidence staff informed the physician as ordered and stated he/she did not know what happened. Failure to inform the physician of Resident #27's weight fluctuations as ordered had the potential for the resident's condition to decline and/or	F 281		

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F 281	Continued From page 20 prevent the physician from making timely changes in treatment. RESIDENT #15 Refer to F 329 for additional information related to monitoring Resident #15's medications. A Minimum Data Set (MDS, required assessment tool) dated 3/20/14 identified Resident #15 had diagnoses that included anemia, heart failure, high blood pressure, kidney failure and diabetes. A physician order dated 2/8/13 directed staff to obtain blood tests to check Total Iron Binding Capacity (TIBC) and a Basic Metabolic Panel (BMP) every three months or six months due to a diagnosis of iron deficiency anemia. A TIBC blood test determines if there is too much or too little iron in the blood. A BMP is a group of blood tests that measures sugar (glucose) level, electrolyte, fluid balance and kidney function. Resident #15's record contained a TIBC blood test last obtained on 8/7/13.The most recent BMP test completed in Resident #15's record was dated 12/28/13, more than three months ago. On 4/7/14 at 3:15 p.m. Staff MR reported the lab came twice a week to obtain blood work. Staff MR also reported a lab slip should be placed into the lab book to alert them to do blood work for a resident. Staff MR looked in the book and did not locate any standing orders for Resident #15 that would have included the TIBS or BMP lab tests needed to be done. On 4/7/14 at 3:50 p.m. the CRN reported the TIBS test should have been done in November 2013 and the BMP repeated in March 2014. On 4/7/14 at 3:57 p.m. the RVP did not know why	F 281		

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F 281	Continued From page 21 Resident #15's labs were not done and needed to clarify the orders with the physician. On 4/9/14 at 1:13 p.m. the DNS reported lab work needed should be noted in medication record to remind nurses to ensure they were done. The DNS confirmed Resident #15's medication records did not contain a reminder for nursing the resident needed repeat, routine lab work. Failure to follow physician orders to obtain lab workfor Resident #15 prevented the physician from having clinical information necessary to make determinations regarding this resident's treatment plan.	F 281		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to ensure licensed staff had a facility policy and procedure for guidance to identify how to monitor residents with edema in accordance with plans of care for 5 of 7 Sampled Residents (#s 3, 13, 27, 52 & 63) reviewed for either unnecessary medications, pain or non-pressure skin conditions. This had the potential for staff to not timely identify changes in resident's medical	F 282	F-282 5-6-14 **How the nursing home will correct the deficiency as relates to the resident:** Resident 3's edema is being monitored according to physician orders. Physician was notified of weight changes per perimeters assigned by the physician. Resident 13's edema is being monitored according to physician orders. Physician was notified of weight changes per perimeters assigned by the physician.	

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F 282	Continued From page 22 conditions and notify their physicians to provide them with an opportunity to timely alter resident treatment plans. Findings include: The standards of nursing conduct or practice is described under Washington Administrative Code or WAC 246-840-700 which refers to the Nursing Practice Act. A registered nurse initiates data collection and analysis that includes pertinent objective and subjective data regarding the health status of the clients. The registered nurse uses client data and nursing scientific principles to develop nursing diagnosis and to identify client problems in order to deliver effective nursing care. The RN plans nursing care. According to Fundamentals of Nursing, Lippincott, Williams, & Wilkins, 7th Edition 2011, page 559: Focused assessments are completed to assess specific problems that occur in patients. The information is used to formulate nursing diagnoses that require nursing care and monitoring of the patient. Page 326: Documentation is the record of pertinent interactions with the patient- assessing, diagnosing, planning, implementing and evaluating. Nursing interventions are documented as closely as possible to their execution. Indicate in each entry the date and time of pertinent observations and interventions. Note problems as they occur in an orderly, sequential manner. Resident #3, Resident #13, Resident #27, Resident #52 and Resident #63 had histories of fluid changes and/or edema. Licensed staff care planned to monitor these residents for edema.	F 282	Resident 27's edema is being monitored according to physician orders. Physician was notified of weight changes per perimeters assigned by the physician. Resident 52's edema is being monitored according to physician orders. Physician was notified of weight changes per perimeters assigned by the physician. Resident 63's edema is being monitored according to physician orders. Physician was notified of weight changes per perimeters assigned by the physician. **How the nursing home will act to protect residents in similar situations.** An audit was complete of the Residents in the facility for physician notification of weight changes per the perimeter assigned by the physician, and edema monitoring.	

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F 282	Continued From page 23 On 4/9/14 at 5:42 p.m. LN D reported when conducting nursing admissions of new residents he/she did not have a tool in place to remind nursing to monitor a resident for edema and medication and treatment records did not identify to monitor for edema. LN D also reported if a resident had "chronic issues" nursing should flag the record to monitor for edema. LN D did not know of a facility and procedure that identified a system for staff to use to monitor residents for edema or forms to document results. On 4/10/14 at 2:06 p.m. the DNS reported the facility did not have system in place to monitor edema and would look for a written policy. On 4/10/14 at 2:18 p.m. LN C reported nursing should monitor edema and check for pitting and correlate with weight changes. Pitting edema can be demonstrated by applying pressure to the swollen area by depressing the skin with a finger. If the pressing causes an indentation that persists for some time after the release of the pressure, the edema is referred to as pitting edema. Any form of pressure, such as from the elastic in socks, can induce pitting with this type of edema. LN C also reported nursing should document results on resident medication records. LN C did not recall if the facility provided training or had a policy in place that addressed edema monitoring. Resident #3's Hydration Plan of Care directed staff to measure legs if edema was present. The facility did not provide a copy of a specific policy and procedure related to edema monitoring or evidence staff were trained to identify specific	F 282	**Measures the nursing home will take or the systems it will alter to ensure that the problem does not occur.** Staff received an education to ensure physician notification of weight changes per the parameters assigned by the physician, and edema monitoring procedure according to the Lippincott manual 10th edition. **How the nursing home plans to monitor its performance to make sure that solutions are sustained.** An audit will be performed weekly by the Director of Nursing and/or designee complete of the Residents in the facility for physician notification of weight changes per the perimeter assigned by the physician, and edema monitoring. Any identified issues will be corrected immediately and any trends will be turned in to the Quality Assurance committee for the next sixty days or further as determined by the Quality Assurance Committee. **The title of the person responsible to ensure correction.** **Director of Nursing** _____	

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F 282	Continued From page 24 staff responsibilities regarding when, what method or how often to monitor residents for changes in edema and where to document the information. Refer to F 309 for failure to monitor edema and/or correlate with weight changes for Resident (#s 3, 13, 27, 52 & 63). Refer to F 333 for failure to administer medication for weight gain for Resident #3. <Edema> Resident #13 4/4/14 at 1:50p.m. Interview with staff NA C and NA D revealed, " Resident #13's feet always look swollen. Resident #13 has had swelling for at least 2 years. NA D stated," Resident #13 is in a wheelchair that tilts back; the feet can't be on a foot rest and the resident's feet are sometimes dangling. We've asked therapy if there is a wheelchair with special feet rest. I asked about it 6 months to a year ago." NA C revealed, "Resident #13 prefers to stay up in wheelchair. Resident #13 has some slippers that are really boots that cut into Resident #13's skin." 4/4/14 at 2:06 p.m. Record review of Minimum Data Set (MDS, an assessment tool) and Care Plan. Care plan from 6/29/09 indicated Resident #13 was at risk for skin impairment/pressure-related skin issues due to immobility, diabetes and morbid obesity. Goal #3 for Resident #13: "will have no increase in pedal edema." Interventions written on the care plan include #4: "Encourage Resident #13 to lie down in the bed 1-2x a day to elevate legs." Goal # 5:	F 282		

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F 282	Continued From page 25 "As needed edema measurements-report changes to MD." At 2:20 p.m. an observation was done of Resident #13 with NA C and NA D. Resident #13 was sitting in a tilt space wheelchair by the bed. The problem according to NA A was that "the feet have to be above heart." NA C and NA D took the stockings off of resident to assess resident's feet and found swelling and pitting of bilateral feet, "more than usual." Said they would tell the nurse. LN B came into Resident #13's room at 2:25 p.m. Assessed Resident #13's feet and reported a blister kind of bruise to the left toe and left foot 2-3+ pitting edema. LN B reported the right foot had 2-3+ pitting edema and a blister to right 3rd toe. LN B acknowledged the feet were dangling off the foot rest. LN B reported not being aware of the left toe bruise. On 4/7/14 at 11:05 a.m. an interview with DNS (Director of Nursing Services) regarding how to monitor edema revealed, "Skin checks are what nurses do per room number per day. Skin assessment is what I do as follow up for pressure ulcers. Some folks have chronic edema. Some folks have it no matter what you try." At 11:15 a.m. an observation of Resident #13 revealed the resident was sitting on a tilt space wheelchair in dining room with left foot on foot rest, right foot dangling.	F 282		

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F 282	Continued From page 26 An interview with DNS at 11:35 a.m. revealed there were no policies on edema. A page from the facility Lippincott manual on how to check for edema was provided as what the facility standard was by the DNS. At 2:05 p.m. an interview with LN C revealed that Resident #13 "had bad edema about a year ago." On 4/8/14 at 9:55 a.m. An interview with PT revealed, "When the wheelchair is so wide, Resident #13's hips aren't against it well." PT reported Resident #13 "has not ambulated in 2-1/2 years. Not sure why. " At 10:57 An interview with LN A revealed the resident prefers to sit up than lie down. 4/9/14 at 5:16 p.m. Interview with LN D revealed, " There are no measurements, no tools, and no monitors for edema. All is subjective. I assess the edema multiple times per shift. Resident #13's edema is much better than it was." LN D agreed to find evidence of documentation regarding Resident #13's edema. LN D also agreed to assess the resident's feet and tell the surveyor about them. LN D stated that usually LN D is an admission nurse or doing admission assessments. LN D reported being on the floor and not finding time to do other things that are needed. LN D revealed at 5:25 p.m. "I didn't touch them	F 282		

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F 282	Continued From page 27 but Resident #13's feet showed 3-4 plus non-pitting edema, bilaterally." The failure of the facility to consistently follow the care plan and to measure the edema as needed resulted in Resident #13 currently at 4+ pitting edema bilaterally, which can result in skin color changes, ulcers, and infection. <Edema and Pain> Resident #52 Admitted on [redacted]13 with diagnoses including atrial fibrillation, hypertension, diabetes mellitus II, hyperlipidemia, depression, respiratory failure and status post [redacted] On 4/3/14 at 10:03 a.m. an observation of Resident #52 revealed swelling in both legs. Resident #52 stated, "I spoke yesterday with LN C who said the concern would be written on the board. I get shooting pains, constant pain that can't be relieved. I really don't tell them about my pain. I took Tylenol around 4-5 p.m. last night. The last couple nights it ripped up my stomach. It makes me scream. I won't tell them I cry. I have a bad back, shoulders in pain, up my neck, my arms, carpel tunnel, I've had charley horses. I have talked to MD but not about the pain." A record review at 10:20 a.m. revealed that on the care plan for 1/10/14 there was a problem of neuropathy. The goal was "Pain management program is meeting resident's needs of comfort." Facility intervention was to "medicate as ordered by the primary care physician." No mention of edema care.	F 282		

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F 282	Continued From page 28 An interview with NA B at 10:40 a.m. revealed, "Resident #52 is alert and would put on call-light but I am not aware of any pain or discomfort." At 10:55 a.m. an interview with LN C revealed, "Resident #52 rarely complains of pain. During the dial-a-lift pick up Resident #52 complains. As long as Resident #52 walks it's a miracle. Lyrica helps Resident #52 with diabetic neuropathy. Cellulitis is part of infection control. We check on it if there is discomfort or if there are issues. Resident #52 asked once last week for pain medication. " At 11:10 a.m. an interview with PT revealed PT "walks with Resident #52 and the resident randomly complains of pain to the left hip." The record review at 11:33 a.m. revealed a Pain Interview was done on 3/10/14 by LN B when "Resident #52 rated pain at 8 out of 10. The resident stated the pain had been experienced over the last 5 days as almost constant. Pain was worse in the evening. Resident stated sleep is affected, decrease in participation, decrease in activities of daily living (ADLs). No side effects from pain medication oxycodone hydrochloride (an opioid analgesic). Non-drug approaches include distraction and rest. Since admission pain has been moderately controlled. " Review of evening shift medication administration record (MAR) from 3/2/14 to 4/2/14 prior to	F 282		

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F 282	Continued From page 29 medication. Pain was 6/10 to 7/10. Non-pharmacological intervention was repositioning and was documented as non-effective. Post medication pain is described 10 out of 16 times between 3/2/14 and 3/20/14 as unable to describe/quantify. 4/7/14 at 3:45 p.m. Resident #52 was observed flat in bed asleep. Both legs swollen and are flat in bed. An interview at 5:45 p.m. with LN D who "looked in on patient" and saw resident's edema as "2 plus non-pitting edema on the left. The right foot has 1+ non-pitting edema. "LN D revealed most of LN D practice was in admissions and "didn't have the chance to do other things on the floor." On 4/10/14 at 2:45p.m DNS did rounds on Resident #52 to assess edema. Found resident had bilateral pitting edema, right foot 4+, left foot 3+. The failure of the facility to ensure quality of care in accordance with the written plan of care placed the resident at risk of increased discomfort and potential skin injury from edema.	F 282		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309		5-6-14

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F 309	Continued From page 30 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 either consistently monitor residents who had a history of edema, non-pressure skin conditions or pain. The facility also failed to continue monitoring for potential injury following a fall or timely referred for a pacemaker check for 8 of 9 Sampled Residents (#s 3, 9, 13, 15, 27, 52, 60 & 63) reviewed for either pain, unnecessary medications, non-pressure skin conditions or accidents of the 28 residents who were included in the Stage 2 review. These failures had the potential to place residents at risk for lack of timely detection of declines in medical conditions. Findings include: RESIDENT #3 - EDEMA MONITORING A hospital History and Physical dated 11/22/13 identified Resident #3 had multiple heart conditions that included congestive heart failure (CHF) and had a pacemaker. CHF occurs when the heart is unable to provide sufficient pumping action to meet the needs of the body. Symptoms can include shortness of breath and leg swelling/fluid retention. The hospital report identified the hospital physician ordered administration of intravenous diuretic medication (Lasix, medication given to eliminate excess body fluid) to the resident to remove excess fluid retention.	F 309	**F309** 5-6-14 **How the nursing home will correct the deficiency as related to the resident:** Residents #3, 27, 63 were assessed for edema with MD notification. Resident #3's pacemaker was checked. Resident #15's non pressure skin condition was assessed and documented. Resident #52's pain was assessed and MD notified. Resident #60 was assessed for use of a PRN medication for anxiety.	

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F 309	Continued From page 31 Upon return to the facility, the physician directed staff to administer Lasix to Resident #3 daily. On 12/31/13 the physician changed the order to give Lasix as needed for weight gain of 2 pounds (lbs) in a week. A "Cardiovascular" Plan of Care dated 4/25/13 included interventions for staff to monitor for signs of reduced cardiac output and to monitor appearance. Interventions included looking for peri-orbital edema (puffiness around the eyes). A "Hydration" Plan of Care contained an intervention to monitor for dependent edema (lower leg edema) and if present, to assess, measure and notify the physician. On 4/9/14 at 1:45 p.m. Resident #3 sat in a wheelchair at the nursing station. The DNS raised the resident ' s right pant leg and the lower right leg appeared to be slightly edematous. The DNS reported the resident had some edema. On 4/9/14 at 5:30 p.m., LN D reported he/she did not think Resident #3 had edema in legs. When asked how nursing staff would know if a resident had edema LN D reported use of Lasix for heart failure would be an indicator and also the care plan. On 4/10/14 at 2:35 p.m. the surveyor and the DNS entered Resident #3's room. The DNS pulled up the resident's pant legs and lowered socks exposing slender legs. The resident had a ridge mark on the skin above the left ankle and the area above the ridge appeared slightly swollen. The DNS reported the resident's "socks are way too tight." A leg catheter bag on the right lower leg had two elastic straps that secured the	F 309	**How the nursing home will act to protect residents in similar situations:** Resident's skin/edema will be monitored weekly. Any changes will be documented and MD notified. Pacemaker information will be placed in the resident's medical record. Pain will be monitored per facility policy when a request for PRN pain medication or complaint of pain is received. **Measures the nursing home will take or the systems it will alter to ensure that the problem does not occur:** Licensed nurses will be educated regarding consistent monitoring, assessment, documentation and MD notification of resident change of condition.	

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F 309	Continued From page 32 top and bottom portion of the bag to the leg. The leg above and below the bands appeared slightly swollen. A vital sign record identified on 4/7/14 Resident #3 weighed 129.2 lbs. A Quarterly Minimum Data Set (MDS, required assessment tool) identified the resident measured five feet, two inches tall. Resident #3's weight records identified the resident had more than 2 lbs of weight gain between 1/7/14 and 1/12/14 (4 lb. gain) and gained 2.8 lbs. between 2/2/14 and 2/9/14. During two weeks between 3/24/14 and 4/7/14, the resident gained 4.6 lbs. The DNS reported an interim weekly weight obtained on 3/30/14 of 117 lbs. was not accurate. Resident #3's record did not contain evidence staff documented they monitored the resident for development of edema routinely or with weight gain, either through use of plus signs used to indicate the level of edema or through measurements as indicated in the plan of care. The record did not identify staff assessed and correlated the residents general condition with weight gains since readmission to the facility on 11/24/13, following hospitalization and treatment for CHF. Refer to F 281 for failure to follow physician orders to consistently weigh weekly and F 333 for failure to administer a diuretic medication for weight gains of 2 lbs in a week. RESIDENT #27 - EDEMA MONITORING A hospital History and Physical dated 11/1/13 identified Resident #3 had multiple heart conditions that included CHF and peripheral	F 309	**How the nursing home plans to monitor its performance to make sure that solutions are sustained:** The Director of Nursing or designee will complete audits weekly for consistent monitoring of resident change of condition. Any issues will be corrected immediately. Information will be presented to the Quality Assurance Committee for the next 60 days **The title of the person to ensure correction.** Director of Nursing	

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F 309	Continued From page 33 edema (the swelling of tissues, usually in the lower limbs due to accumulation of fluid). The resident received treatment to remove excess fluid accumulation between the lining of the outside of the lungs and the wall of the chest (thoracenteses). A hospital Discharge Summary dated [redacted]13 documented Resident #27 had multiple diagnoses that included a severe to critical heart condition; irregular heart rhythm; history of CHF and high blood pressure. The summary identified the resident received treatment for a chronic lung condition and required oxygen therapy. At the onset of hospitalization, the summary indicated the resident had slight "volume-overload" (excess fluid in the body) and received a diuretic (Lasix) and heart medication. Following admission to the facility on [redacted]13 the facility physician ordered for staff to monitor Resident #27's weight twice a week and to notify the physician of weight gain or loss of greater than 2 lbs. and ordered daily administration of a diuretic beginning 11/11/13. On 4/1/14 at 4:37 p.m., 4/3/14 at 11:54 a.m. and 4/8/14 at 7:20 p.m. Resident #27 remained in room and breathed concentrated oxygen treatment breathed through a tube placed at the base of the nose (nasal oxygen). On 4/10/14 at 2:28 p.m. the surveyor and the DNS observed Resident #27 sitting on the edge of the bed with nasal oxygen treatment in place. The DNS reported the resident had chronic weight fluctuations and pressed a finger onto the resident's lower legs and reported the resident had 2+ edema (pitting edema). The resident	F 309		

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F 309	Continued From page 34 reported he/she just saw the physician and had another thoracenteses scheduled. A "Hydration" Plan of Care dated 2/7/14 included interventions to monitor for signs and symptoms of fluid overload that included sudden weight gain and to monitor for dependent edema. Resident #27's record did not contain evidence staff documented they monitored the resident for development of dependent edema as indicated in the plan of care. The resident ' s medical record did not contain evidence staff notified the physician of weight changes greater than 2 lbs on eight occasions noted between 1/8/14 through 4/6/14. Refer to F 281 for failure to follow physician orders and notify the physician of weight changes. RESIDENT #63 EDEMA MONITORING A nursing note dated 3/15/14 documented Resident #63 developed an abnormal heart rhythm and sent resident went to the hospital. Hospital admission dictation notes dated [redacted]14 indicated Resident #63 had a recent history of a severe stroke and had an irregular heart rhythm. Additional medical history diagnoses included high blood pressure and chronic congestive heart failure with swollen bilateral lower extremities noted as 2+ pedal edema (swelling of ankles and feet). When Resident #63 returned to the facility on 3/17/14, the physician directed staff to administer blood pressure medication and increased frequency of a diuretic medication (Lasix) to twice	F 309		

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F 309	Continued From page 35 a day. Previous to hospitalization on 3/15/14, the resident received Lasix once a day. A readmission nursing assessment conducted [redacted]14 when Resident #63 returned to the facility, noted the resident had 2+ edema in both lower extremities. A physician interval visit note dated 3/25/14 documented the resident had chronic edema. An undated "Hydration" Plan of Care included interventions to monitor the resident for symptoms of fluid overload that included sudden weight gain and edema. A "Vital Sign & Weight Record" identified Resident #63 gained 5.6 lbs between 3/24/14 and 4/7/14. Resident #63's record did not contain evidence staff continued to monitor for presence of bilateral lower leg edema since the initial nursing readmission assessment on 3/17/14 or correlate the weight gain with other potential clinical signs. On 4/9/14 at 5:30 p.m. LN D did not know if Resident #63 had leg edema when asked. LN D did not think staff monitored the resident for leg edema. While seated in the dining room at this time, the resident's feet and ankles appeared edematous. On 4/10/14 at 2:25 p.m. Resident #63 lay in bed in room. When the DNS pulled up the resident's pant legs ridge marks were visible where the elastic at the bottom of the pant legs rested against the skin near the ankle. The DNS reported the resident "needs pants without elastic to not make it so tight around" the legs. The resident's legs appeared edematous.	F 309		

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F 309	Continued From page 36 On 4/9/14 at 5:42 p.m. LN D reported when conducting nursing admissions of new residents he/she did not have a tool in place to remind nursing to monitor a resident for edema and medication and treatment records did not identify for staff to monitor for edema. LN D also reported if a resident had "chronic issues" nursing should flag the record to monitor for edema. LN D did not know of a facility policy and procedure that identified a system the facility used to monitor residents for edema. On 4/10/14 at 2:18 p.m. LN C reported he/she would check for pitting and correlate with weight changes if a resident had edema. LN C also reported edema monitoring should be done as a standard of practice and nursing should document results on resident medication records. O 4/10/14 at 2:25 p.m. the DNS reported staff monitored the condition of resident's skin weekly and would document on the medication record a note concerns of edema using a "+" sign. The DNS also reported nursing staff should call the physician if edema developed, got worse, had significant changes in weight and nursing staff should use "common sense." The facility did not have a written policy and procedure in place that identified how to monitor for changes in edema, how often to monitor, what method to use and guidelines to determine when to notify physicians of resident changes in edema. Resident #3, Resident #27 and Resident #63 had histories of CHF and additional complicating conditions that placed them at risk for	F 309		

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F 309	Continued From page 37 development or continued edema and/or excess fluid accumulation in the body. No evidence was found in their records staff routinely monitored residents for edema or correlated all clinical information and documented results to determine if resident conditions worsened or remained the same. Failure to routinely monitor and assess and document for changes in edema and weight, and correlate changes with additional clinical information, had the potential to place these residents at risk for untimely or undetected further medical complications and/or delayed notification of physicians if significant changes in condition occurred that required timely intervention. RESIDENT #3 - PACEMAKER A hospital History and Physical dated 11/22/13 identified Resident #3 admitted to the hospital with congestive heart failure (CHF), uncontrolled high blood pressure, an enlarged heart, dementia and a heart condition that caused an irregular heartbeat that limited the heart's ability to pump blood to the rest of the body) and had a pacemaker. A hospital history and physical dated 11/22/13 indicated the resident required and had a pacemaker inserted in 2006. A significant Change Minimum Data Set (MDS, assessment tool) dated 12/4/13 identified Resident #3 returned to the facility on [redacted]13 with a history of heart failure, arrhythmia, diabetes, history of stroke, vision concerns. The MDS also identified the resident had impaired cognition and difficulty with inattention and disorganized thinking. A Plan of Care dated 4/25/13 for "Cardiovascular"	F 309		

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F 309	Continued From page 38 status related to having a pacemaker included an intervention for pacemaker checks according to the physician order. On 4/8/14 at 2:40 a.m. when asked about the resident's pacemaker, LN A did not know for sure if the resident had one and did not locate information regarding the pacemaker on nursing medication records. With surveyor present, LN A checked the resident and observed the resident had a pacemaker implanted under the skin in the upper chest. The resident informed the nurse h/she was due to see the doctor to have the pacemaker checked. Following this observation, LN A discussed the pacemaker with LN E who reported the facility had a pacemaker form to use that identified for staff when a resident needed the next pacemaker check. On 4/8/14 at 2:48 p.m. LN E reviewed Resident #3's admission nursing assessment dated [redacted]13 which indicated the resident's last pacemaker check occurred December 2012 or January 2013. LN E reported Staff MR kept track of appointments needed and looked in a book at the nursing station and reported the facility used a transportation book to keep track of resident appointments. LN E looked in the transportation book and reported she did not locate a follow up appointment form from the resident's last visit that would indicate when and where the resident needed the next pacemaker check. On 4/8/14 at 2:53 p.m. the DNS reported usually Staff SS or Staff MR kept track of pacemaker appointments. The DNS also reported nursing staff were expected to put information regarding	F 309		

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F 309	Continued From page 39 pacemakers on medication records so they were aware. On 4/8/14 at 3:16 p.m. Staff MR reported Resident #3's contacting Resident #3 ' s medical provider and just made an appointment for a pacemaker check for 4/11/14. Staff MR showed the surveyor a "Pacemaker Data" form used by the facility for tracking pacemaker checks due. Staff MR did not locate the tracking sheet in Resident #3's record when she looked. On 4/8/14 at 3:50 .am. Staff CRN reported Resident #3 needed to have a pacemaker check done every six months. Failure to timely refer Resident #3 for a pacemaker check had the potential for the provider to not know if the pacemaker malfunctioned or needed to have the battery replaced. NON-PRESSURE SKIN MONITORING RESIDENT #15 On 4/7/14 at 1:20 p.m. LN C and the surveyor looked at Resident #15's skin. The resident had a moderately colored redness in the right abdominal/groin fold. Quarterly Minimum Data Set (MDS, a required assessment tool) dated 10/9/13 identified Resident #15 admitted to the facility in 2012 with multiple diagnoses that included diabetes, heart failure and anemia. MDS dated 10/9/13 and quarterly MDS's dated 1/1/14 and 3/20/14 all identified the resident had moisture associated skin damage (MASD),	F 309		

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F 309	Continued From page 40 required extensive assistance from staff for bed mobility, transfers and toileting needs. MDS's dated 1/1/14 and 3/20/14 identified Resident #15 required extensive assistance form one staff for personal hygiene. December 2013 Treatment Records documented the physician ordered an anti-fungal cream treatment to Resident #15's right abdominal/groin area skin fold beginning 12/4/13. Staff documented they applied the cream twice a day beginning the evening of 12/10/13. Treatment records documented continued treatment through 1/31/14 and continued and changed treatment multiple times through 4/7/14. February 2014 Treatment Record identified staff administered a different topical cream three times a day for 14 days 2/1/14 through 2/14/14 to the right abdominal/groin skin fold and reported results to the physician on 2/7/14 as ordered. March 2014 Treatment Records identified the physician ordered a different antifungal/antibiotic powder to treat under the right abdominal/groin skin fold as needed. Staff documented they applied treatment seven times 3/11/14 through 3/25/14. April 2014 Physician Orders identified the physician discontinued use of the antifungal/antibiotic powder as needed on 4/3/14. Staff began administration of the same antifungal ointment prescribed for 14 days in February (2/1/14 through 2/14/14). The physician ordered the antifungal treatment three times a day for 14 days beginning 4/3/14 to the right abdominal/groin skin fold. Treatment records documented staff continued to apply the ointment	F 309		

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F 309	Continued From page 41 as ordered through 4/7/14 when records were reviewed by the surveyor. A care plan dated 3/20/14 for "Skin Impairment related to Chronic/recurrent rash" to right groin skin fold included interventions for staff to monitor for redness or complaint of discomfort; ensure prompt skin care; provide treatments as ordered by the physician and assess, evaluate and document progression of skin injury healing every week. Resident #15's medical record did not contain evidence staff comprehensively assessed the condition of skin rash located in the right abdominal/groin skin fold when treatment first began 12/4/13. Resident #15's record contained a facility titled "Integumentary/Feet" form for skin assessment dated 3/5/14 that identified a rash located in the right abdominal/groin skin fold and noted "closed rash better then I've seen." The skin assessment did not contain further appearance of the rash such as color or extent of area involved (size). On 4/7/14 at 1:30 p.m. LN C confirmed the skin assessment dated 3/5/14 did not include measurements of the skin area involved. Following a request for all skin assessment/monitoring documents for the resident's skin conditions, on 4/7/14 at 1:25 p.m. the facility provided "Weekly Skin Measurement Tool" forms dated 3/14/14 and 4/8/14 identified for use to document monitoring pressure ulcers. The skin form dated 3/5/14 did not identify the extent of skin area involved or size of "redness" noted to the abdominal/groin skin fold.	F 309		

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F 309	Continued From page 42 The facility did not provide evidence staff continued to monitor the abdominal/groin skin rash for 13 weeks between 12/4/13 and 3/5/14 or weekly for three weeks after 3/14/14 through 4/8/14. On 4/7/14 on 1:04 p.m. the DNS reported staff should document monitoring the condition of Resident #15's abdominal/groin skin rash on "non-pressure" skin forms until resolved. The DNS also reported the pressure ulcer skin form staff used did not "fit" to monitor the condition of the resident's non-pressure skin issue. The DNS looked in the facility procedure book and did not locate a non-pressure skin form staff could use to document monitoring non-pressure skin conditions. Immediately following the interview with the DNS, LN C reported skin sheets were not started earlier than those provided (3/14/14) and reported staff kept track of the skin condition during skin rounds. On 4/7/14 at 1:39 p.m. the CRN reported nursing should document non-pressure skin conditions weekly on the "Integumentary/Feet" forms. The DNS confirmed staff did not use that form to monitor Resident #15's skin. Failure to initially comprehensively assess the condition of a non-pressure skin condition that included characteristics and extent of size or consistently and routinely monitor the condition, had the potential to prevent all staff that treated the condition to not have baseline or current information regarding the extent of the skin	F 309		

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F 309	Continued From page 43 condition. This failure prevented staff from having adequate information to compare the skin condition week to week to determine if the skin condition improved or declined and/or timely determine if and when a change in treatment were needed. RESIDENT #9 FAILURE TO CONTINUE TO MONITOR FOR 72 HOURS AFTER A FALL Resident #9 re-admitted to the facility on [redacted]14. A scheduled assessment dated 3/5/14 identified the resident's diagnoses included a heart condition, pneumonia and a respiratory condition requiring medical intervention. The assessment indicated the resident had no prior history of falls, received physical therapy and required supervision/cueing for transfers and daily care. On 4/1/14 at 1:45 p.m. Resident #9 walked independently in the hallway with a walker. Later at 1:52 p.m. the resident sat in a chair in the hall across from the dining area and conversed with staff. A facility investigation documented on 3/26/14 at 7:45 p.m. Resident #9 fell on the floor in room. The resident reported to staff feeling "funny" and fell to the floor. The resident alerted staff and reported bumping h/her head and did not feel the need to go to the emergency room. Investigation notes indicated the resident had a lump on the scalp one inch behind the hairline on the right side of the head. A "Neurological Assessment Flow Sheet" identified staff initiated assessment of the resident's neurological status that included vital signs (blood pressure, pulse, temperature and	F 309		

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F 309	Continued From page 44 respirations, level of consciousness, mental orientation and eye pupil reactions). The neurological assessment form directed staff to assess the resident every 15 minutes for one hour; followed by every 30 minutes for one hour; then hourly for two hours then every shift for the next 24 hours. On 4/9/14 at 11:09 a.m. the DNS reported after initial neurological checks were done Resident #9 should be placed on the 24 Hour Report to alert staff for need to continue alert charting. The DNS stated nursing documentation should indicate if the resident demonstrated any latent sign of injury, if neurological checks were done or if the resident complained of pain. At this time, the DNS spoke with LN B regarding the alert charting process. LN B reported nursing should document alert charting once every shift for 72 hours. The DNS reported there were two shifts. One shift began 2:00 a.m. to 2:00 p.m. and a second shift began 2:00 p.m. to 2:00 a.m. Staff documented they last monitored Resident #9 during the "AM" shift on 3/27/14, the following morning after the fall. Notes on the neurological assessment form to indicate monitoring the resident the last 12 hours during the "PM" shift on 3/27/14 were left blank. The record did not contain evidence staff continued to monitor Resident #9 during the evening shift on 3/27/14 or through 3/29/14 at 7:45 p.m. (72 hour period of time after the fall). Nursing documentation did not identify staff continued to monitor the resident for changes specifically related to the fall or potential consequences of bumping head. A note dated	F 309		

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F 309	Continued From page 45 3/27/14 timed 10:00 p.m. documented staff administered medication for resident complaint of nausea. The note did not identify if staff assessed further to rule out nausea as a potential symptom related to a head injury. On 4/9/14 at 11:25 a.m. the DNS reported nursing should continue alert charting for 72 hours after the time of the incident. A copy of the 24 Hour Report provided by the DNS indicated Resident #9 had a "fall" and did not identify the resident hit h/her head. On 4/9/14 at 11:25 a.m. the DNS confirmed should continue alert charting for 72 hours bginning from the time of incident. Nursing documentation for the entire 72 hours after Resident #9 fell and hit h/her head did not identify staff continued to monitor the resident for potential effects of latent head injury after the morning shift the following day to assure the resident did not develop signs or symptoms that required immediate medical attention. RESIDENT #13 - EDEMA MONITORING 4/4/14 at 1:50p.m. Interview with staff NA C and NA D revealed Resident #13 has had swelling for at least 2 years. "It happens when the resident drinks more than resident should. We report it to the nurse. We remind the resident that the feet are swollen; chose to not be on liquid limits. Resident #13 likes to drink more than eat. Resident #13 likes milk, orange juice and cocoa.We've asked therapy if there is a	F 309		

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F 309	Continued From page 46 wheelchair with special feet rest. I asked about it 6 months to a year ago. " Care plan review at 2:06 p.m. from 6/29/09 indicated Resident #13 was at risk for skin impairment/pressure-related skin issues due to immobility, diabetes and morbid obesity. Goal #3 for Resident #13: " will have no increase in pedal edema. At 2:20 p.m. an observation was done of Resident #13 with NA C and NA D. Resident #13 was sitting in a tilt space wheelchair in the bedroom. NA C and NA D took the stockings off of resident to assess the feet and found swelling and pitting of bilateral feet,"more than usual." On 4/7/14 at 11:15 a.m. an observation of Resident #13 revealed the resident was sitting on tilt space wheelchair in dining room with left foot on foot rest, right foot dangling. At 11:35 a.m. The director of nursing (DNS) took a look at feet and noticed that feet are not elevated. An interview with NA E at 1:40 p.m. revealed, "We're trying to watch fluids. I don't know how much Resident #13 drinks or urinates." At 2: 05 p.m. an interview with LN C revealed that Resident #13 had bad edema about a year ago. " Resident #13 and family won ' t agree to a fluid restriction program. So, Resident #13 is the last in the bathroom and the first to leave the dining room. Resident #13 drinks milk, apple juice, and cocoa. " On 4/8/14 at 9:55 a.m. an interview with PT revealed, "When the chair is so wide, Resident #13's hips aren't against it well. The previous one was 2 inches narrow. PT was concerned with it	F 309		

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F 309	Continued From page 47 breaking down skin." PT reported, " Edema of both feet was monitored for skin breakdown. I don't know that a catheter pad would keep it from going down on the floor. With anything you add on, you have to question, will it work, and will it be ok. Resident #13 has had no complaint of discomfort. In Resident #13's case just ask if the resident wants the wheelchair tilted or not. Resident #13 doesn't like the foot rest. There is no therapy as it would be only for wheelchair positioning. Resident #13 has not ambulated in 2-1/2 years. Not sure why. A possibility is compression wraps. Perhaps Resident #13 is potentially in bed too much. Resident #13 doesn't want to be tilted. " On 4/8/14 at 10:15 a.m. A Risk and Benefits Consent form was found in Resident #13 ' s chart indicating that on 3/24/14 the resident ' s POA signed, "I do not consent to the Fluid Restriction -I prefer to make my own food choices. I understand the risks of this decision. I also understand that my decision can be changed at any time." On 4/8/14 at 10:57 Interview with LN A revealed that LN A was not sure "what arm bruises are from. They sometimes are in arm or leg. Hard to know what causes them. Feet are always edematous. We try to put Resident #13 back to bed. Feet are swollen. Lots of edema in lower feet. We just put them up with pillows on bed. The resident keeps them down in wheelchair. We get leg rests on chairs. We try. " 4/9/14 at 9:35 a.m. Resident #13 found in bed with a pillow between the legs. When NA B was asked, reported the feet should have elevated with pillows under the feet.	F 309		

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F 309	Continued From page 48 4/9/14 at 5:16 p.m. Interview with LN D revealed, "There are no measurements, no tools, and no monitors for edema. All is subjective. I assess the edema multiple times per shift. Resident #13's edema is much better than it was. " LN D agreed to find evidence of documentation regarding Resident #13's edema. LN D also agreed to assess the resident's feet and tell the surveyor about them. LN D stated that usually LN D is an admission nurse or doing admission assessments. LN D reported being on the floor and not finding time to do other things that are needed. 4/9/14 at 5:25 p.m. LN D revealed " I didn ' t touch them but Resident #13 ' s feet showed 3-4 plus non-pitting edema, bilaterally. " 4/10/14 at 2:20 p.m. DNS provided a copied page (p. 69 under Adult Physical Assessment) from the facility Lippincott manual which demonstrated palpation of extremities to determine edema. 4/10/14 at 2:30 p.m. DNS agreed to accompany survey team on rounds to assess edema on Resident #13. Resident #13 was found sitting in wheelchair in room with curtain separating residents in Resident #13's face. Reported Resident #13 to have right foot 4+, right leg 1+ and left foot at 4+ pitting edema. DNS was told from Resident #13's roommate curtained off area by unidentified staff that Resident #13 was "awaiting a chair to help keep feet elevated in wheelchair since Resident #13 doesn't like to lay down." Refer to F315 for urinary incontinence	F 309		

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F 309	Continued From page 49 RESIDENT #52 Resident #52 was admitted initially on [redacted]13 then readmitted after hospitalization on [redacted]14 with diagnoses that included hypertension, renal insufficiency, diabetes mellitus II, hyperlipidemia, depression, and status post [redacted] 4/3/14 at 9:50 a.m. Interview with Resident #52. Resident reported problems with right leg due to an accident when 26 years old. "Nerve pain in the early 90's was diagnosed as diabetic neuropathy. Shooting pain started 2 weeks ago from foot to hip and back to foot. Last 2 nights it was so bad I haven't been able to sleep. " At 9:53 on observation Resident #52 was noted with swelling in both legs. "For alternative pain relief I used deep heat. I get shooting pains, constant pain that can't be relieved. I really don't tell them about my pain. I took Tylenol around 4-5 p.m. the last couple nights and it ripped up my stomach. It makes me scream. I won't tell them I cry. I have a bad back, shoulders in pain, up my neck, my arms, carpel tunnel, and I've had charley horses. I have talked to MD but not about the pain. I am managing it. I have a sore on the bottom of foot. I have callus build up on the stub of my surgical site. I was rubbing my foot. I can pull it up and the stub callus burst open. Looked like a beehive. POD saw it the other morning. " 10:20 a.m. The care plan for Resident #52 was reviewed for 1/10/14. A stated problem was neuropathy. The goal was, " Pain management program is meeting resident's needs of comfort. " An intervention was medicating as ordered by the	F 309		

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F 309	Continued From page 50 primary care physician. At 10:40 a.m. an interview with NA B revealed that Resident #52 was alert and would put on call-light but NA B was " not aware of any pain or discomfort. " At 1:53 p.m. an interview with LN C revealed, " Resident #52 picks on [redacted] callus and started on the right callus. The resident called it diabetic ulcers. Resident #52 was seen in the wound clinic. Is in and out of the hospital. Had tried to used TENS unit to help with stimulation of tissue. Resident #52 rarely complains of pain. When had to use the dial-a-lift for appointments would then complain of pain. As long as the resident walks it's a miracle. Lyrica helps with diabetes neuropathy but doesn't use it. The resident ' s leg is looked at during night shift. Dressing on toe is changed on night shift. Resident #52 does know if there is complete numbness. The resident asked once last week for pain medication. It's random when Resident #52 asks for it. " 4/3/14 at 11:10 p.m. An interview with Staff PT who revealed walking with Resident #52 and the resident " would randomly complain of pain to the left hip. " At 11:40 a.m. an interview with LN B revealed, " Therapy walks with Resident #52. I wasn ' t aware the pain was still not in control. "	F 309		

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F 309	Continued From page 51 On 4/3/14 at 11:50 p.m. a record review revealed a pain interview was done on 3/10/14. Resident #52 rated pain at 8/10. Resident #52 revealed pain had been experienced over the last 5 days " as almost constant. Pain is worse in evening. " When asked how pain interferes with everyday life, Resident #52 reported sleep is affected, there is decreased participation, decreased activities of daily living (ADLs) and as needed (prn) Oxycodone relieved pain. No side effects to pain medication. Nondrug approaches used according to the pain interview included distraction and rest. Since admission pain control has been moderate. 12:44 p.m. review of prn medication administration report (MAR) for 3/2/14 to 4/2/14 for Resident #52. Pre-medicated pain was 6/10 to 7/10 and given for " general " location of pain. Non-medication intervention was repositioning and was documented as non-effective. Post-medication pain was described 10 out of 16 times between 3/2/14 and 3/20/14 as " unable to describe/quantify. " 4/3/14 at 2:27p.m. Interview with LN B. Reported Resident #52 had pain control and seemed satisfied with current activity level. When asked if Resident #52 seemed sad or having psychosocial issues related to pain, LN B replied "was not aware but will check in with resident." 4/4/14 at 9:44 a.m. Staff LN B revealed having interviewed Resident #52 the day before. LN B reported Staff LN B ' gratefully ' accepted offer of mental health evaluation. LN B also reported being now aware of resident ' s pain concerns.	F 309		

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F 309	Continued From page 52 On 4/7/14 at 3:45 p.m. Resident #52 was observed flat in bed asleep. Both legs were swollen and not elevated. 5:45 p.m. Interview with LN Dwho " checked and saw resident's edema continues. It is 2+ not-pitting edema on the left and on the right there was 1+ non-pitting edema. " LN D acknowledged not having palpated Resident #52 ' s feet. On 4/10/14 at 2:20 p.m. Staff DNS was asked for facility policy/procedures for managing edema. DNS stated there was not a policy but did have a copy of the Adult Physical Assessment page from the facility Lippincott manual. Confirmed Resident #52 was currently on Lasix 20mg po daily. At 2:25 p.m. DNS agreed to assess Resident #52's feet for edema. Reported it was "4+ pitting edema on the right and 3+ pitting edema on the left." RESIDENT #52 - PAIN RECOGNITION AND MANAGEMENT See F3282 for Skin Condition non-pressure related RESIDENT #60 Resident#60 was admitted on [redacted]4 with diagnoses including personal history of fall; depressive disorder, iodiopathic peripheral neuropathy, diabetes type II.	F 309		

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F 309	Continued From page 53 4/3/14 at 2:05 Interview with Resident#60 who reported, " My right knee is very painful. I can't afford a knee replacement. I told doctor that since the x-ray showed a bad knee, I was told to get over the counter medicine. The staff here told me I can't take my Aleve because it interacts with meds taken here. " Staff LN C walked in with a pill and resident didn't want to talk. After taking the pill, the resident stated wanted to proceed with interview. Interview resumed at 2:10 p.m. Resident #60 reported, " I don't think the meds will work because leg has gotten worse...I want to get my own apartment through the state. I get real anxiety with staff OTR in the afternoon and OTR just doesn't take no. I don't know what to do... OTR kept going over the same things. I have dyslexia and OTR had me do exercises that I couldn't do. I don ' t want OTR anymore. OTR stresses me out. A Buspar was brought to me to deal with OTR. I spoke to someone about not working with OTR and they told me I had to work with OTR and I was really stressed and in pain. I can't work with OTR if I don't have Buspar. This all started recently; I don't want to deal with 3 people a day; they told me I should work just morning and afternoon and it should be left that way. It's too much for me to work three times a day. I'm worse off when I leave therapy than when I go in. OTR just stresses me out. OTR knows I don't like puzzle and games and OTR still gives me a puzzle. None of it helps my pain. I want to be on my own. "	F 309		

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F 309	Continued From page 54 2:45 p.m. Observation of therapy session with Resident #60 and staff OTR. OTR comments to Resident #60 during therapy, " Are you counting? Keep breathing. You're mixing up. " Resident #60 ' s response, " I have a learning disability. I didn't get my nap today. " OTR replied, " You're my last one anyway. We want to help with your standing balance to help improve core strength. " Resident #60 reported being done and session ended. Interview at 3:40 p.m. with staff NA B. Reported Resident #60 often appeared with " Agitation, upset facial expressions, not normally pain but like agitation. Resident #60 doesn't like to be watched. " 4/4/14 at 11:55 a.m. Record review of medication administration record (MAR) revealed Resident #60 is on Gabapentin 600mg by mouth (po) three times a day (TID) for peripheral neuropathy; Celexa 40mg po each morning for depressive disorder; Norco 5/325mg orally every 4 hours prn, Tramadol 50mg as needed, every six hours prn pain management. Lidocaine 5% ointment ordered four times prn topically for pain relief of right knee. Buspar 10mg orally was changed from scheduled dosing to prn (Buspar 10mg, oral, each morning and evening prn for anxiety state) on 3/28/14. At 12:20 p.m. The record review of physician ' s orders revealed a late entry from 4/3/14 to discharge Resident #60 from skilled occupational therapy.	F 309		

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F 309	Continued From page 55 At 12:36 p.m. A review of pain interview done on 2/7/14 by staff LN B revealed resident does complain of aching pain at a rate of 10/10. The pain was almost constant and was worse from mid morning to the afternoon. It interfered with activity. Nondrug approaches included rest and wanted to have a level of pain relief to be able to sleep comfortably. Acknowledged neuropathy and the evaluation by the LN B was that the pain managament plan was effective. At 12:45 an interview with LN C revealed, " Resident #60 has adequate pain control. Resident #60 is a good sleeper. Since Resident #60 is not on Trazadone we don't keep a sleep log on the resident. " On 4/7/14 at 3:55 p.m. An interview with Resident #60 who reported, " I am very sore because I was out all day. I had pain medication earlier today. Did therapy this morning; the therapist was a substitute and said that I could do my own exercises. Nothing really helps my pain. They want me to try a pain cream but I don ' t like it. " The facility ' s failure to monitor resident ' s response to therapy, using Buspar prn, and resident's poor pain control placed Resident #60 at risk for increased psychosocial stress.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		

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F 315	Continued From page 56 Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure appropriate treatment and services to restore as much normal bladder function as possible in 2 of 2 Sampled Residents (#1, #13) reviewed for incontinence of the 28 Residents who were included in Stage 2. This resulted in placing the residents at risk of acquiring urinary tract infections. Findings include: Resident #1 Admitted on [redacted]13 with diagnoses including diabetes mellitus II, CVA, hemiplegia, and depression. 4/4/14 at 3:10 p.m. Interview with Resident#1 in resident's room. "I have no problems going to the bathroom." Resident stated that moving to wheelchair then to bathroom is fine.	F 315	**F315** **How the nursing home will correct the deficiency as related to the resident:** Residents #1 and #13 were assessed for bladder management programs. **How the nursing home will act to protect residents in similar situations:** Residents will be assessed on admission, quarterly and with significant change for appropriate bladder management programs.	5-6-14

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F 315	Continued From page 57 4/4/14 at 4:15 p.m. Record review of Minimum Data Set (MDS, an assessment tool) revealed that on 12/18/13 resident was triggered as "frequently" incontinent. On 3/7/14 resident was triggered as "always" incontinent. MDS is not marked for a bladder program. On 4/7/14 at 1:50 p.m. an interview with NA E revealed Resident #1 "sometimes asks but does not like us to check in or ask how the briefs are that are worn. States that all is fine. No urinals have been tried. Resident #1's skin is ok on the bottom." Record review of plan of care dated 3/10/14 revealed a problem of skin impairment related to gluteal crease maceration as related to finding on quarterly MDS review dated 3/7/14 of moisture associated skin damage. 4/7/14 at 3:10 p.m. Interview with DNS and with LN B who stated resident is aware of urge but refused to use bathroom as a choice due to frustration. An updated (1/27/14) Resident Status sheet indicates under 'Bladder' that resident is incontinent, has a urinal, and uses briefs. No urinal was found in resident vicinity. Observation on 4/8/14 at 715 a.m. No smell of urine. Watching TV. When asked how sleep was overnight, Resident #1 started to shake left arm and said 'they checked on me already.' Breathing labored. NA B reported Resident #1 is usually incontinent when up in the morning.	F 315	**Measures the nursing home will take or the systems it will alter to ensure that the problem does not occur:** An education was provided to the nursing staff regarding how to assess residents need for a bladder management program.	

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F 315	Continued From page 58 An Interview with LN A at 10:50 a.m. revealed resident, "mostly asks to go to the bathroom but I'm not sure. Sometimes the resident is incontinent or goes to bathroom. Not sure. There are different kinds of incontinence; they all deserve to be toileted, a regular pattern. I don't know if Resident #1 is on an incontinence type plan." Resident was sent to hospital due to increased respiratory distress. Resident #13 Admitted to facility on [redacted]13 with diagnoses including hypertension, hernia, renal insufficiency, chronic heart failure, diabetes mellitus II, thyroid disorder, edema, dementia and depression. 4/4/14 at 2:23 p.m. Interview with NA C and NA D. "We have no possible way to get Resident #13 into the bathroom on time. The incontinence was more bowel than bladder. Now it seems more bladder than bowel incontinence. When we do changes the resident will be dry then will be wet. A Hoyer lift is used to transfer the resident." At 1:40 p.m. an interview with NA E revealed, "Resident #13 is incontinent of bladder." A record review of Minimum Data Set (MDS, an assessment tool) dated 5/7/13 revealed resident was 'always' incontinent. No toileting program was coded. Functional status was coded as total dependence with Two+ persons physical assist. The care area assessment (CAA, an assessment	F 315	**How the nursing home plans to monitor its performance to make sure that solutions are sustained:** The Director of Nursing or designee will assess each resident incontinence status to determine need for bladder training program. Assessments will also be done quarterly and with significant change of incontinence. If issues are noted they will be corrected immediately. The gathered data will be presented to the Quality Assurance committee for the next 90 days. **The title of the person responsible to ensure correction:** Director of nursing	

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F 315	Continued From page 59 tool) dated 6/14/13 indicated Resident #13 had been hospitalized on [redacted]14 for diagnoses of abdominal pain and chest pain secondary to diabetic gastroparesis, large ventral hernia, and uncontrolled diabetes. According to record review, Resident #13 had a Foley catheter while at the hospital. The hospital transfer summary dated [redacted]14 revealed an order, "May D/C Foley cath at SNF." Under Type of Incontinence, the CAA dated 6/14/13 analysis of findings revealed Toileting was triggered due to resident" being totally incontinent of urine and being dependent on staff for incontinence care. Resident urinates almost continuously---resident has no bladder control---this is a long term problem. Resident is on high dose of diuretics." According to the medication administration record for the facility, Resident #13 is currently on Lasix 80mg by mouth every day. On 4/8/14 a record review revealed the facility Risk and Benefits Consent was signed by Resident #13's POA on 3/24/13 to have a "no consent to fluid restriction as resident is able to make own choices and guide own medical care and decisions." At 10:25 a.m. an interview with staff RD revealed Resident #13 "went on a normal soup kick then wanted a food jag. Education doesn't help; Resident #13 not motivated." At 10:57 a.m. an interview with LN A revealed, "I	F 315		

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F 315	Continued From page 60 constantly check Resident #13 daily, really. Up to bathroom. Incontinent not sure of what. " An interview with LN B at 2p revealed, "Resident #13 is a check and change at this time." Record review of ADL flow records from July 2013 through April 2014 reveal Resident #13 was incontinent between 3 and 8 times per shift. Resident #13 had extensive to total dependence for toilet use. Resident was offered fluids 3 times/day during both night and day. The failure of the facility to develop a toileting program for chronic incontinence placed the resident at risk for urinary tract infection and moisture associated skin damage.	F 315		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure all doors that exited the building were	F 323	**F323** **How the nursing home will correct the deficiency as related to the resident:** Resident 34 was immediately assessed when injury occurred and investigated. A door monitoring process was immediately initialized until door alarm could be installed. Alarm was placed on the door by the nurse's station.	5-6-14

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F 323	Continued From page 61 secured and/or alarmed and failed to adequately supervise to prevent access to an unsafe area in the facility for 1 of 4 Sampled Residents (#34) reviewed for accidents. As a result, Resident #34 entered a hallway intended only for staff access and fell down a flight of stairs in a wheelchair and sustained a cervical fracture. This injury constituted harm for this resident. Findings include: Resident #34 admitted to the facility on [redacted]14 following hospitalization. A hospital "Resident Discharge Summary" dated [redacted]14 documented the resident fell at home, had severe osteoporosis, a history of previous surgical repair of a left hip fracture and sustained new non-displaced fractures of pelvic bones, right hip and right upper arm. A facility diagnostic list identified Resident #34 had a history of a heart condition, pacemaker and Alzheimer's disease. The summary identified the resident did not require surgery and discharged to the nursing home for rehabilitation. A Minimum Data Set (MDS, required assessment tool) dated 1/29/14 identified Resident #34 had moderately impaired vision, had cognitive impairment and did not know the correct year, month or day, required extensive assistance from two staff for bed mobility, transfer, dressing and hygiene and had functional limitation of one side of an upper extremity. The MDS also indicated the resident had difficulty with focusing and inattention, became easily distracted, disorganized thinking and had hallucinations and delusions.	F 323	**How the nursing home will act to protect residents in similar situations:** An audit of exiting doors was completed and exiting doors now alarm. **Measures the nursing home will take or the systems it will alter to ensure that the problem does not occur:** Staff will be educated regarding door alarms and increased supervision for residents to ensure they are not entering employee areas.	

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F 323	Continued From page 62 On [redacted]14 at 9:08 a.m. Resident #34 [redacted] and sat in a wheelchair in the dining room engaged in an activity. On 4/8/14 at 9:18 a.m. Resident #34 [redacted] while Staff NA A pushed the resident in a wheelchair down the hall. Staff NA A stopped at a doorway to a bathroom and the resident used both feet to self-propel the wheelchair a short distance inside. On 4/9/14 at 7:50 a.m. Resident #34 [redacted] and propelled the wheelchair using both feet to move down the hall into the dining room. Physician orders on 2/7/14 directed staff to administer a psychoactive medication to treat dementia with behaviors. On 3/13/14 the physician increased the dose when the resident continued to have confusion and make paranoid statements and did not redirect easily. On 3/24/14 the physician discontinued the first psychoactive medication and implemented use of a different one. A nursing note dated 3/14/14 documented the physician changed psychoactive medications since the first one prescribed was ineffective to treat agitated behaviors. A "Fall Management" Plan of Care dated 1/22/14	F 323	**How the nursing home plans to monitor its performance to make sure that solutions are sustained:** Maintenance Director or designee will monitor door alarms weekly with his safety rounds. Any issues will be reported to the Administrator and corrected immediately and presented to the Quality Assurance committee for review for the next 60 days. **The title of the person responsible to ensure correction:** **Maintenance Director**	

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F 323	Continued From page 63 identified risk for falls included a history of falls, fractures, pain, incontinence, dementia, medication use, sensory impairment and had dementia with behaviors. An aide care plan dated 1/23/14 identified the resident used a front wheeled walker only with therapy staff. Nursing notes dated 1/23/14 through 3/26/14 identified Resident #34 exhibited confusion with agitation at times and usually could be re-directed. Notes indicated the resident could make needs known and self-propelled in the facility in a wheelchair. Nursing notes documented the resident attempted to seek a means to exit the facility on 2/19/14; 2/20/14 and 3/13/14. On 3/19/14 staff documented the resident walked in the hall without a walker and poorly understood safety teaching. On 3/20/14 staff documented the resident attempted to exit seek more than 10 times during the shift, twice on 3/21/14 and attempted to exit seek on 3/23/14 and 3/24/14. Facility "Event & Occurrence Reports" identified Resident #34 experienced two falls in the facility since admission. Both times, the resident did not use a call light to summon staff for assistance. On 2/17/14 at 3:20 a.m. an investigation documented Resident #34 slid off the bed onto the floor during an attempt to get up to go to the bathroom. A second facility investigation identified on 2/28/14 at 4:00 a.m. staff found Resident #34 on the floor. The resident reported falling trying to go to the bathroom. The conclusion of the investigation identified the resident had rehab, got stronger and attempted to self-transfer and had	F 323		

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	505515	A. BUILDING _____ B. WING _____	04/11/2014

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F 323	Continued From page 64 confusion at times. A nursing note dated 3/26/14 at 1:00 p.m. documented Resident #34 self-propelled "around facility" in a wheelchair. A facility investigation report dated 3/31/14 identified at 8:15 p.m. on 3/26/14, staff discovered Resident #34 at the bottom of a stairwell that led to the basement (in the facility) and sent the resident to the emergency room. Staff documented in the investigation the resident self-propelled in the wheelchair about 8:00 p.m. during an attempt to enter another resident's room. Staff re-directed the resident to the Fireside Room. Approximately 15 to 20 minutes later, staff looked for the resident and a nurse saw the resident's slipper in the doorway that led to the stairs. Staff located the resident at the bottom of the stairs with head at the bottom and legs extended toward the top of the stairs and the wheelchair turned over. The investigation conclusion stated the resident went through two doors to get to the stairs. All other doors in the facility were alarmed and no resident had gone through those doors before. The day following this incident, the facility added a keypad alarm to the door that led to the area before the door before the stairwell. On 4/9/14 at 10:17 a.m. a door located in front of the nurses' station contained a large "STOP" sign visible at standing eye level and another sign below that which indicated "Staff Only." Sign placement was not at eye level if seated in a wheelchair. Staff MR reported at this time the same sign was on the door before the facility	F 323		

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F 323	Continued From page 65 installed the new digital keypad. On 4/9/14 at 10:34 a.m. the RVP reported two aide staff were busy caring for another resident the evening Resident #34 fell. When they were done and went to look for resident they did not locate her. The RVP reported no other residents had wandered through the door in front of the nursing station before. The RVP also reported the facility had residents in the past who were exit seekers. On 4/3/14 at 12:32 p.m. Staff FMD reported the facility just installed the alarm system on the door (in front of nurse station) last Friday (3/28/14). The FMD reported staff entered the door to go downstairs and now the door would alarm when pushed open. On 4/9/14 at 3:40 p.m., The DNS reported facility doors that exited in the front of the building, back hallway, dining room and therapy room all had alarms to signal staff when they were opened. The surveyor and the DNS then looked at the location where Resident #34 fell. Inside the first door in front of the nursing station a short distance down the hall there was a second unlocked and unalarmed door. A short distance past the second door a third door exited the building There was a set of stairs on the right immediately before the third exit door that led to the basement. The DNS identified Resident #34 fell down this flight of stairs. The DNS reported before Resident #34 fell, the facility did not have a lock or alarm on the door in front of the nursing station and just recently added an alarm to the door to alert staff if a resident opened the door. The DNS reported the	F 323		

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F 323	Continued From page 66 third door (that exited the facility) remained locked so no one could enter the building from the outside. Resident #34 remained hospitalized from [redacted]14 following the fall until re-admission to the facility on [redacted]14. A hospital "Admission History and Physical" dated 3/27/14 identified the resident's current fall down the stairs resulted in a fracture in a bone located in the upper cervical spine and the resident would need to [redacted] for 3 months. A hospital Physical Therapy Evaluation dated [redacted]14 indicted Resident #34 could return to the facility to prior level of functional mobility and needed to [redacted] 24 hours a day seven days a week. The report also indicated the resident alert, "pleasantly confused" and followed instructions about 75% of the time. Resident #34 had high risk for falls that included a history of cognitive impairment; recent history of falls resulting in fractures; recent psychoactive medication adjustments; self-propelled in the facility in a wheelchair and pattern of exit seeking. The facility failed to identify the need to alarm a door that led to an unsafe area for residents to alert staff if entered by the resident. Staff failed to provide adequate supervision to ensure Resident #34's safety to prevent the resident from entering this unsafe area. This led to Resident #34 falling down a flight of stairs which resulted in fracture in a bone in the upper neck which constituted harm for this resident.	F 323		
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329		

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F 329 SS=D	Continued From page 67 UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to adequately and/or consistently monitor effectiveness and/or side effects for use of either blood pressure, anti-psychotic or sleep medications for 2 of 5 Sampled Residents (#s 3 & 15) reviewed for medication use. These failures had the potential for residents to receive medications that were ineffective or to not timely	F 329	**F329** **How the nursing home will correct the deficiency as related to the resident:** Resident #3 and 15's medications were reviewed and monitors put in place to assess efficiency and side effects of medications. **How the nursing home will act to protect residents in similar situations:** An audit will be complete of current resident to ensure Monitors will be put into place for resident medications as required and to assess efficiency of side effects.	5-6-14

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F 329	Continued From page 68 identify if residents developed adverse side effects. Findings include: RESIDENT #3 Refer to F 309 for additional medical history for Resident #3 and failure to monitor for edema and timely refer for pacemaker follow up. 1. A hospital History and physical dated [redacted]/13 identified Resident #3 admitted to the hospital with multiple medical conditions that included poorly controlled high blood pressure and heart failure and had a pacemaker. The resident returned to the facility two days later on [redacted]13. April 2014 Physician Orders included an order dated 10/26/13 to administer a medication to treat high blood pressure (Lisinopril) every morning. On 12/1/13 the physician directed staff to monitor Resident #3's blood pressure weekly. December 2013 Medication Records (MAR) contained highlighted weekly dates staff should check the resident's blood pressure. The MAR and vital sign sheets did not contain evidence staff obtained Resident #3's blood pressure 12/21/13 as highlighted or for 15 days between 12/12/13 through 12/28/13. On 4/8/14 at 3:50 p.m. following a request for additonal informaiton, Staff CRN did not provided further information why blood pressures were not consistently monitored for Resident #3. The facility did not provide evidence of consistent monitoring requested during a meeting on 4/11/14	F 329	**Measures the nursing home will take or the systems it will alter to ensure that the problem does not occur:** Licensed nurses were educated regarding consistent monitoring and documentation of medications for efficiency and side effects **How the nursing home plans to monitor its performance to make sure that solutions are sustained:** Medical records or designee will audit MAR's weekly for accurate and consistent monitoring of medication as required. Any issues found will be reported to the Physician for further clarification. The data will be presented to the Quality Assurance committee for the next 60 days.	

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F 329	Continued From page 69 at approximately 2:30 p.m. and did not have a written facility policy and procedure for monitoring vital signs. Failure to consistently monitor use of a blood pressure medication had the potential for staff to not readily determine ongoing effectiveness of blood pressure medication or if Resident #3 developed complications requiring immediate medical intervention. 2. Current Physician Orders for April 2014 contained an order dated 10/23/13 for staff to administer 25 mg of an anti-psychotic medication (Seroquel) at bed time. Potential side effects for Seroquel include orthostatic hypotension. Orthostatic hypotension is a sudden and significant change in blood pressure that can occur during changes of body position such as lying to sitting and sitting to standing that could cause fainting. This had the potential to increase these residents risk for falls. On 8/21/13 the physician directed staff to monitor orthostatic blood pressures monthly on the 14th of every month. Resident #3's medical record did not contain evidence the facility obtained an orthostatic blood pressure on 12/14/13 or 1/14/14 or anytime during December 2013 or February 2013. On 4/2/14 at 9:42 a.m. LN C reported staff found Resident #3 fell trying to get up on own and required assistance form one staff to transfer safely. LN C also reported the resident self-propelled while in the wheelchair.	F 329	**The title of the person responsible to ensure correction:** Director of Nursing	

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F 329	Continued From page 70 On 4/7/14 at 9:00 a.m. Resident #3 sat on the edge of the bed in room. On 4/8/14 at 3:50 p.m. the CRN was advised of monitoring concerns and would look into it. The facility did not provide further information or explanation why staff did not consistently monitor use of Lisinopril or Seroquel for potential side effects. The facility did not provide a copy of the facility policy and procedures related to medication monitoring as requested on 4/11/14. Failure to adequately monitor for side effect of orthostatic hypotension had the potential to increase Resident #3's risk for falls. RESIDENT #15 Refer to F 309 for additonal observations and medical history. Om 4/3/14 at 1:32 p.m. and on 4/4/14 at 111:52 a.m. Resident #15 lay in bed and slept with the door open. Diagnoses listed on April 2014 Physician Orders included depression, anxiety, chronic pain and restless legs syndrome. A physician's order dated 5/24/12 directed staff to give Resident #15 a medication at bed time to treat restless leg syndrome. A physician's order dated 1/31/14 directed staff to administer a different medication (Mirtazipine) for sleep and anxiety at bed time to the resident.	F 329		

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F 329	Continued From page 71 On 4/7/14 at 3:49 p.m., when asked how staff monitored effects of medication given to aid with sleep, the CRN reported if staff gave a medication to a resident to help them sleep the number of hours of sleep should be monitored. The CRN also reported "I would expect it" would be documented on medication records. On 4/7/14 at 4:05 p.m. the SSD reported Resident #15 may have difficulty sleeping due to anxiety and has awakened in the middle of the night for a snack before. Medication Records for 3/1/14 through 4/6/14 did not contain evidence staff monitored the effect of Mirtazapine on Resident #15's sleep pattern to determine if the medication was effective. On 4/9/14 at 2:42 p.m. the DNS reported the facility did not have a written policy and procedure that addressed monitoring of sleep medications. The DNS also reported staff should monitor the number of hours residents slept if given medications for sleep.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to	F 332	**F332** **How the nursing home will correct the deficiency as related to the resident:** Resident # 1, #14, and #38 medication errors were reported to the Physician Nurse received an education regarding proper med pass.	5-6-14

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F 332	Continued From page 72 ensure 3 out 28 sampled residents (#1, #14, #38) were receiving their medications without error. This failure placed residents at risk for complications of disease process. Findings include: Resident #1 Admitted on [redacted]13 with diagnoses including diabetes mellitus II, cardiovascular accident, hemiplegia, depression, and respiratory failure. 4/2/14 at 9:30 a.m. Resident #1's order was for Miralax 17 gms in 8oz fluid; LN C stated there was "120cc in the cup" and the cup was observed 3/4 full. The cup was measured out at 30cc increments and was found to hold 240cc. The amount which was being used to dissolve the Miralax was less than the ordered 240cc during medication administration. Resident #38 Admitted on [redacted]11 with diagnoses including atrial fibrillation, hypertension, thyroid disorder, and cardiovascular accident. 4/2/14 at Resident #38 was given Lisinopril 20 mg by mouth and Atenolol 25 mg by mouth in a.m. without pulse or blood pressure checks. MD order was to hold Lisinopril if pulse is less than 60 or systolic blood pressure (SBP) is 110. There was no information to indicate the residents pulse and blood pressures were obtained. Resident #14	F 332	**How the nursing home will act to protect residents in similar situations:** Pharmacy Consultant and or designee will perform a skills check for licensed nurses for medication dispersion. **Measures the nursing home will take or the systems it will alter to ensure that the problem does not occur:** Licensed nurses were educated regarding the 5 rights of medication administration and accurate documentation	

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F 332	Continued From page 73 Admitted on [redacted]13 with diagnoses including anemia, hypertension, hyperlipidemia, dementia, and anxiety. Resident#14 was given Omeprazole over an hour after eating breakfast. The doctor's order was for the resident to receive the medication at least 1 hour before meals. An interview with the DNS on 4/3/14 at 8:45 a.m. revealed that an Omnicare pharmacist, Staff RX, does the monthly medication review and a Regency corporate nurse consultant watches medication passes quarterly.	F 332	**How the nursing home plans to monitor its performance to make sure that solutions are sustained:** Director of Nursing or designee will audit medication pass weekly. If any issues are found they will be corrected immediately. The data will be presented to the Quality Assurance committee for the next 60 days.	5-6-14
F 333 SS=D	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 observation, interview and record review it was determined the facility failed to ensure residents were free of significant medication errors for 1 of 5 Sampled Residents (#3) reviewed for unnecessary medication use of the 28 residents who were included in the Stage 2 review. Staff failed to administer a diuretic (medication to reduce fluid retention in the body) on three occasions. Failure to administer a diuretic when needed had the potential for this resident to experience a decline in medical condition, create discomfort and constituted	F 333	**The title of the person responsible to ensure correction:** Director of Nursing **F333** **How the nursing home will correct the deficiency as related to the resident:** Resident #3's medication order was clarified.	

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F 333	Continued From page 74 significant medicaiton errors. Findings include: Refer to F 309 and F 281 for failure to consistently monitor edema and consistently follow physician orders. On 4/10/14 at 2:35 p.m. Resident #3 lay in bed with socks on. The resident's left lower leg above the top a sock worn appeared slightly puffy. The DNS pulled down the resident's left sock and the skin below the sock band revealed a ridge in the skin. The DNS reported the resident's "socks are way too tight." A hospital History and Physical dated [redacted]13 identified Resident #3 had multiple heart conditions that included congestive heart failure (CHF) and required a pacemaker. CHF occurs when the heart is unable to provide sufficient pumping action to meet the needs of the body. Symptoms can include shortness of breath and leg swelling. The hospital treated Resident #3 with an intravenous diuretic (Lasix) to eliminate excess fluid and to administer diuretics as needed for comfort afterward. The hospital admitted the resident for 24 hours and sent the resident back to the facility. On 12/1/13 the physician ordered for staff to administer a diuretic medication (Lasix) 10 mg as needed weekly if Resident #3 gained 2 pounds in a week. On 1/7/14 staff documented Resident #3 weighed	F 333	**How the nursing home will act to protect residents in similar situations:** An audit of Residents with order for Lasix were reviewed for proper assessment and administration of ordered medication. **Measures the nursing home will take or the systems it will alter to ensure that the problem does not occur:** Education was given to licensed nurses regarding Giving medications as ordered by the MD.	

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F 333	Continued From page 75 129 lbs. On 1/12/14 staff documented on the vital sign record the resident weighed 133 lbs, showing a weight gain of 4 lbs. from the previous week. Weekly weight records identified Resident #3 gained more than 2 lbs from the previous week on 2/9/14 and 4/7/14. The resident gained 2.8 lbs from the prior week on 2/9/14 and gained 4.8 lbs from the prior week on 4/7/14. Medication records for the resident did not contain evidence staff administered 10 mg after the resident gained more than 2 lbs in a week on 1/12/14, 2/9/14 or 4/7/14. On 4/8/14 at 3:50 p.m. the surveyor informed Staff CRN regarding concern Resident #3 did not receive lasix when needed. Staff CRN reported he would look into it. The facility did not provide further evidence the resident received lasix for weight gain of over 2 lbs in one week. On 4/10/14 at 2:52 p.m. the DNS reported staff should have administered Lasix to Resident #3 on 4/7/14. Failure to administer Lasix to treat weight gain from fluid had the potential for Resident #3's cardiac condition to worsen and/or increase discomfort.	F 333	**How the nursing home plans to monitor its performance to make sure that solutions are sustained:** Medical Records or designee will audit weekly for documentation of Lasix given as ordered. Any issues found will be corrected immediately. Findings will be presented to the QA committee for 60 days **The title of the person responsible to ensure correction:** Medical Records **F354** **How the nursing home will correct the deficiency as related to the resident:** Nursing schedule was adjusted to ensure RN coverage 16 hours a day	5-6-14
F 354 SS=F	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours	F 354		

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F 354	Continued From page 76 a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the use of a registered nurse for at least 8 consecutive hours on 3/8/14 and 3/22/14. The failure to ensure the facility used the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week placed the residents at risk of not reaching their highest practicable level of well-being. On 4/9/14 at 10:05, the Staffing Pattern review from 3/18/14 to 3/31/14 revealed that on 3/22/14 there was no registered nurse present during day or evening shift. Licensed practical nurses were on duty during both 12 hour shifts. The DNS acknowledged that the lack of registered nurses on consistent 8 hour shifts was a problem that will be looked at very carefully to ensure coverage. On 4/11/14 an audit was done of the Staffing Pattern between 3/2/14 and 3/18/14. It revealed that on the dates of 3/6/14, 3/7/14, 3/8/14, 3/13/14, 3/14/14, and 3/15/14 there were no	F 354	**How the nursing home will act to protect residents in similar situations:** Nursing schedule was adjusted to ensure RN coverage 16 hours a day **Measures the nursing home will take or the systems it will alter to ensure that the problem does not occur:** Director of Nursing and licensed nurses were educated on need for 16 hr RN coverage	

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	505515	A. BUILDING _____ B. WING _____	04/11/2014

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F 354	Continued From page 77 assigned registered nurses on duty. 3/8/14 and 3/15/14 were Saturdays. The other days were during the week when the DNS acted as charge nurse. The facility had an average daily occupancy of fewer than 60 residents.	F 354		
F 372 SS=F	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure air gaps met the United States Department of Health and Human Services, Food and Drug Administration, Food Code 5-202.13 for preventing sewage from spilling into the system. This failure placed residents at risk for contamination and contracting food-borne illness. Findings include: The United States Department of Health and Human Services, Food and Drug Administration, Food Code 5-202.13 stated an air gap between the water supply inlet and the flood level rim of the plumbing fixture, equipment, or nonfood equipment shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (1 inch). On 4/1/14 the supply inlet pipes for the prep sink, dishwashing machine and the ice machine were at or below the flood level rim.	F 372	F372 **How the nursing home will correct the deficiency as relates to the resident:** No Residents were affected by the air gap in the kitchen The air gap was immediately repaired **How the nursing home will act to protect residents in similar situations** An audit was complete to ensure there were no further air gaps in the facility plumbing **Measures the nursing hom.. intake or the systems it will alter to ensure that the problem does not occur:** An education was given to the Maintenance Director regarding air gap policy and procedure.	5-6-14

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F 372	Continued From page 78 On 4/2/14 The Dietary Manager said the pipes for the prep sink, ice machine and the dishwasher were at or below the flood level rim. On 4/2/14 at 11:00 a.m. the air gaps were observed with the Facility Maintenance Director (FMD). The FMD said the air gaps for the prep sink, ice machine and dishwasher were not twice the diameter of the pipes. The FMD said he was responsible for ensuring the facility's plumbing met the regulations and was not able to recall the requirements for the air gaps.	F 372		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441	**F441** **How the nursing home will correct the deficiency as related to the resident:** LN A and NAC A were in-serviced on infection control practices regarding cross contamination during patient care **How the nursing home will act to protect residents in similar situations:** Nursing staff were educated regarding infection control practices during patient care	5-6-14

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F 441	Continued From page 79 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that staff used appropriate infection control practices designed to prevent cross contamination during resident care for 2 of 3 current staff members (LN A and NA A) reviewed for infection control practices. This failure placed residents at risk for acquiring communicable diseases and infections. Findings include: 1) On 04/01/14 at 1:40 p.m. Licensed Nurse (LN) A wiped Resident #1's buttocks with disposable wipes. LN A wore the contaminated gloves and assisted the resident putting on his brief, grabbed the the resident's wheelchair handles, opened the curtain and touched the resident's shirt. At 2:26 p.m. LN A said she moved the resident's wheelchair after she wiped the resident's buttocks. LN A said she touched the resident's	F 441	**Measures the nursing home will take or the systems it will alter to ensure that the problem does not occur:** Director of Nursing or designee will audit infection control practices weekly. Any issues identified will be corrected immediately. The data will be presented to the Quality Assurance committee for the next 60 days. **The title of the person responsible to ensure correction:** Director of Nursing	

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F 441	Continued From page 80 wheelchair handles with the contaminated gloves. LN A said she should have removed the gloves after she wiped the resident's buttocks. 2) On 04/01/14 at 1:40 p.m. LN A and Nursing Assistant (NA) A was providing incontinence care to Resident #1's. The resident's comforter was observed sitting on top of the garbage can and two pillows were on the floor. NA A picked up the comforter and covered the resident. NA A picked up one of the pillows and placed it under the resident's head. On 4/2/14 at 2:49 p.m. the Director of Nursing Services (DNS) said the resident's comforter and pillows should be kept clean, off the floor and not on garbage can. The DNS said the linens were contaminated and the staff should not have re-used them. The DNS said staffs have been trained to change gloves when the gloves had been dirty. The DNS stated she did rounds and monitored staff during her shift to ensure gloves changed was done and linens were properly changed. On 4/3/14 at 9:00 a.m. Interview with the Director of Nursing (DNS) on need for infection control policy. DNS is new to the DNS/Infection Control Nurse position (hired 2/18/14). The Infection Control and hand washing policies were requested. On record review, the Infection Control Program Overview dated 1/2010 included the establishment of procedures to "Maintain records of incidents and corrective actions related to infections" and "Requiring staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice."	F 441		

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F 441	Continued From page 81 Maintain records of incidents and corrective actions related to infections On 4/3/14 at 9:18 a.m. a record review of the Infection Report and Tracking policy and procedure in the facility infection control book included, "It is the policy of this facility to report, investigate and track infections in order to ensure residents with infections receive appropriate care and services and measures are instituted to prevent the spread of communicable diseases." According to CDC guidelines of Healthcare-associated Infections, 2010, "Because alcohol does not kill Clostridium Difficile spores, use of soap and water is more efficacious than alcohol-based hand rubs." On 4/3/14 at 12:40 p.m. a review of the Infection Control program revealed the last documented tracking was done in November 2013. There was no surveillance documentation done since November 2013. At 12:50 p.m. Interview with infection control nurse (DNS) revealed there was an expectation for infection control rounds done in policy and procedure manual for infection control. DNS acknowledged they had not done one since DNS was hired (2/18/14). An Infection Control Rounds form was provided to the surveyor and included areas of linen handling, hand washing, gloves, personal care items, equipment disinfection, and procedures. The DNS acknowledged not yet documenting facility illnesses on a facility map to	F 441		

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F 441	Continued From page 82 locate infections. Logs have not been done to include documentation of MRSA, C-Difficile, and VRE infections. According to the Infection Report and Tracking portion of the facility Infection Control Manual, "Logs and facility maps will be used to identify trends and for quality assurance purposes." Handwashing The facility had 2 residents with C-Difficille (#52 and #63). On 4/2/14 at 9:44 a.m. when DNS was asked about hand washing procedure by staff for C-Difficille residents, stated, "it can be either gel or hand washing." According to the Regency Pacific, Inc. Policy and Procedure Hand Hygiene Policy, staff was to use either soap and water or alcohol-based hand rub before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice). The Contact Precautions portion of the policy and procedure hand hygiene policy included the purpose, which was to prevent the spread of microorganisms between staff, residents, and visitors. According to CDC guidelines of Healthcare-associated Infections, 2010, " Because alcohol does not kill Clostridium difficile spores, use of soap and water is more efficacious than alcohol-based hand rubs. "	F 441		

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F 441	Continued From page 83 On 4/4/14 at 1:40 p.m. Staff OTR was interviewed with the question, " What instructions have you been given when you go into rooms of residents that are on isolation? " OTR responded, "I'm not sure if we are or are not to do certain things for hand washing with C-Difficile residents." On 4/4/14 at 2:50 p.m., CRN provided an in-service on Clostridium Difficile for nursing staff. On 4/7/14, CRN provided an in-service on Clostridium Difficile for the wider facility staff. On 4/10/14 at 2:50 p.m. rounds were done on Resident #63 by the DNS to assess for edema. The DNS used gel for hand hygiene. After noting surveyors all used soap and water, DNS washed hands with soap and water when doing rounds among other residents with surveyors.	F 441		
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	F 520	F520 **How the nursing home will correct the deficiency as relates to the resident:** The Administrative Staff will discuss in Quality Assurance deficiencies identified in the facility process.	5-6-14

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F 520	Continued From page 84 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure a consistent Quality Assessment and Assurance (QA & A) program. This placed the facility at a lack in accountability for ensuring both resident quality of care and resident quality of life. Interview on 4/9/14 at 2:35 p.m. with Staff Admin and DNS. The Admin acknowledged having attended one QA & A meeting since hired (3/13/14) and the DNS acknowledged having attended two QA & A meetings since hired (2/18/14). The Admin also acknowledged there were QA & A minutes available. The QA & A committee is comprised of the Admin and department heads of the facility and the Admin acknowledged the committee met quarterly.	F 520	**How the nursing home will act to protect residents in similar situations** An education will be complete to the Administrative staff on the reporting of deficiencies in the Quality Assurance Team **Measures the nursing home will take or the systems it will alter to ensure that the problem does not occur:** An education will be complete to the Administrative staff on the reporting of deficiencies in the Quality Assurance Team	

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F 520	Continued From page 85 Quality deficiencies were presented to the Admin and DNS during the interview. The Admin acknowledged, " Action plans include discussion, education, in-services, and implementation. " The Admin reported the QA & A committee had not been made aware of problems with: notifying the physician, care plans, skin monitoring, medical follow-up, stairs, door locking from the outside, call lights, med errors (DNS aware but med errors were not reported to QA & A), air gap, or nursing staffing levels. Admin agreed to provide QA meeting attendance from August 2013 to March 2014. The failure of the QA & A committee to function effectively was acknowledged by the administrative staff .	F 520	**How the nursing home plans to monitor its performance to make sure that solutions are sustained:** An audit will be performed monthly by the Administrator and/or designee regarding Quality Assurance deficiencies in the facility and discussions to improve.. Any identified issues will be corrected immediately and any trends will be turned in to the Quality Assurance committee for the next sixty days or further as determined by the Quality Assurance Committee **The title of the person responsible to ensure correction** Administrator	